TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICT IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER

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BY

SUSSANA YARUSHA JOHN

SUPERVISOR

DR. BHOLESHWAR PRASAD MISHRA

DEPARTMENT OF CLINICAL PSYCHOLOGY
DAYANAND MEDICAL COLLEGE AND HOSPITAL
LUDHIANA,
(MAY, 2021)

DECLARATION

I declare that the dissertation entitled "**TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICT IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER**" has been prepared by me under the guidance of **DR. BHOLESHWAR PRASAD MISHRA** Professor & Head, Department of CLINICAL PSYCHOLOGY, Dayanand Medical College and Hospital, Ludhiana. No part of this dissertation has formed the basis for the award of any degree previously.

SUSSANA YARUSHA JOHN
Department of Clinical Psychology
Dayanand Medical College & Hospital
Ludhiana-141001
Punjab.

CERTIFICATE

I, certify that SUSSANA YARUSHA JOHN has prepared this thesis entitled "**TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICT IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER**" for the award of degree of MPhil in Clinical Psychology of Baba Farid University of Health Sciences, under my guidance. She has carried out the work at the Department of Psychiatry, Dayanand Medical College & Hospital, Ludhiana.

The data collected in this dissertation is genuine and the work has been carried out by the candidate herself.

Supervisor

Dr. Bholeshwar Prasad Mishra
Professor & Head
Department of Clinical Psychology
DMC&H, Ludhiana

Co-Supervisor(s)

Dr. Rupesh Chaudhary
Professor
Department of Psychiatry
DMC&H, Ludhiana

Ms. Palak Upadhyay
Assistant Professor
Department of Clinical Psychology
DMC&H, Ludhiana

Date:

ENDORSEMENT BY THE HEAD OF THE DEPARTMENT AND PRINCIPAL

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Head of Department

Dr. Bholeshwar Prasad Mishra
Professor & Head
Department of Clinical Psychology
DMCH, Ludhiana

Principal

Dr. Sandeep Puri
Principal and Professor
Department of Medicine
DMCH, Ludhiana

Date:

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SUSSANA YARUSHA JOHN
Department of Clinical Psychology
Dayanand Medical College & Hospital, Tagore Nagar
Ludhiana-141001
Punjab.

Date:

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Dedicated to

my teachers,

family &

friends

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LIST OF ABBREVIATIONS

A	ALCOHOL
ACES	ADVERSE CHILDHOOD EXPERIENCES
AVE	ABSTINENCE VIOLATION EFFECT
EB	EXTERNALIZING BIAS
EPA-N	EXTERNAL PERSONAL ATTRIBUTION- POSITIVE
EPA-P	EXTERNAL PERSONAL ATTRIBUTION- POSITIVE
ESA-N	EXTERNAL SOCIAL ATTRIBUTION- POSITIVE
ESA-P	EXTERNAL SOCIAL ATTRIBUTION- POSITIVE
FA	FAMILY AREA
GABA	GAMMA AMINOBUTYRIC ACID
IA-N	INTERNAL ATTRIBUTION-NEGATIVE
IA-P	INTERNAL ATTRIBUTION- POSITIVE
ICD-10	INTERNATIONAL CLASSIFICATION OF DISEASES CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS
IOM	INSTITUTE OF MEDICINE
IR	INTERPERSONAL RELATIONSHIP
MQ-ACH	MOTIVATIONAL QUESTIONNAIRE- ACHIEVEMENT
MQ-AFF	MOTIVATIONAL QUESTIONNAIRE- AFFILIATION
MQ-POW	MOTIVATIONAL QUESTIONNAIRE- POWER
nAch	NEED FOR ACHIEVEMENT
nAff	NEED FOR AFFILIATION
NIDA	THE NATIONAL INSTITUTE OF DRUG ABUSE
NMDA	N-METHYL D-ASPARTATE RECEPTOR
nPow	NEED FOR POWER
NSDUH	NATIONAL SURVEY OF DRUG USE AND HEALTH
O	OPIOID
PACQ	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE
PACQF (RES)	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE-FATHER FORM RESPONSIBILITY FACTOR

PACQF	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE-FATHER FORM
PACQM (CON)	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE-MOTHER FORM CONTROL FACTOR
PACQM (REG)	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE-FATHER FORM REGARD FACTOR
PACQM (REG)	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE-MOTHER FORM REGARD FACTOR
PACQM (RES)	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE-MOTHER FORM RESPONSIBILITY FACTOR
PACQM	PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE-MOTHER FORM
PB	PERSONALIZING BIAS
SA	SEX AREA
SC	SELF CONCEPT
SSCT	SACKS SENTENCE COMPLETION TEST
SUD	SUBSTANCE USE DISORDER
VTA	VENTRAL TEGMENTAL AREA
WHO	WORLD HEALTH ORGANIZATION

ABSTRACT

Introduction: Substance abuse is a common problem among young adults and has devastating effects both on the individual and the family members. These individuals have a different conflicts with the family, self and in interpersonal relationships. They also might have attributional biases to which they aatribute their problem behavior and motivational needs that could be addressed in making a holistic family-based intervention.

Aim of Study: 1) To compare the parental relationship of young adults with and without substance use disorder (SUD). 2) To compare the internal, personal and situation attributional bias in young adults with and SUD. 3) To compare the motivational needs of young adults with and without SUD. 4) To compare the types of conflicts in young adults with and without SUD.

Materials & methods: The cross-sectional study was conducted on patients(N=50) of Substance Use Disorder admitted in psychiatry ward and visiting De-addiction OPD at DMC&H and healthy control group (N=50) from general healthy population. Psychological evaluation was done using The Parent Adult-Child Relationship Questionnaire (PACQ), Internal, Personal and Situational Attribute Questionnaire (IPSAQ), Motivational Questionnaire and Sacks Sentence Completion Test (SSCT).

RESULTS: The study group comprised of two substance use groups-opioid and alcohol use. There was significant difference between the two groups regarding parental relation with father and mother, with lower mean scores for regard factor in mother scale, responsibility and regard factor for father scale and a higher score for control factor, father scale for study group. There was no significant difference in attributional bias but mean score for personalizing bias was higher for the study group. There was significant difference between the mean scores of need for achievement and power, with a higher mean score for nPow and lower mean score for nAch for the control group. There was significant difference seen in all the four areas of conflicts with a higher mean score for study group in the above four areas.

CONCLUSION: There was significant difference between the motivational needs, parental relationship and types of conflicts in between the control and study group, which needs to be considered and addressed in order to plan family based intervention for rehabilitation.

Keywords: Substance use disorder, Types of Conflicts, Parental Relationship, Motivational Needs, Attributional Bias, Drug addicts, Young Adults.

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INTRODUCTION

Substance abuse can be defined as excessive use of a drug in a way that is damaging to self, society, or both. This definition takes into account both physical dependence and psychologic dependence. Physical dependence is said to be caused by prolonged use of a drug refers to an altered physiologic state in which withdrawal symptoms develop when the drug is discontinued. Psychologic dependence refers to a state of intense need to continue taking a drug in the absence of physical dependence.[1] Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can result in dependence syndrome –which is a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling the drug's use, persistence in using it despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.[2]

DIAGNOSTIC GUIDELINES FOR SUBSTANCE USE- ICD-10

According to the ICD-10 criteria recognition of the psychoactive substance used may be made on the basis of self-report data, objective analysis of specimens of urine, blood, etc., or other evidence (presence of drug samples in the patient's possession, clinical signs and symptoms, or reports from informants). It is always considered a better option to seek corroboration from more than one source of evidence relating to substance use.[3]

Many drug users tend to use more than one type of drug, but the diagnosis of the disorder should be classified according to the most important single substance (or class of substances) used. This may usually be done when the individual uses a particular drug, or type of drug, causing the presenting disorder. When doubtful, it is suggested that coding should be done of the drug or type of drug most frequently

misused, particularly in those cases where it is used continuously or daily.[3]

Acute intoxication

A transient condition following the administration of alcohol or other psychoactive substance, causing disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psychophysiological functions and responses.

Diagnostic guidelines

Acute intoxication is mostly closely related to dose levels. Acute intoxication is a transient phenomenon. Intensity of intoxication tends to lessens with time, and effects eventually disappear in the absence of further use of the substance. Recovery is therefore complete except where tissue damage or another complication has arisen because of the intoxication.

Symptoms of intoxication might not always reflect primary actions or effects of the substance: for example, depressant drugs may lead to symptoms of agitation or hyperactivity, and stimulant drugs may lead to socially withdrawn and introverted behaviour. Effects produced by substances like cannabis and hallucinogens may be particularly unpredictable. Moreover, many psychoactive substances produce different types of effect at different dose levels. For example, alcohol may have stimulant effects on behaviour at lower dose levels, eventually leading to agitation and aggression with increasing dose levels, and produces clear sedation at very high levels.

Harmful use

A pattern of psychoactive substance use that produces damaging consequences to individual's health. The damage may include both physical (as in cases of hepatitis from the self-administration of injected drugs) and mental form (e.g. episodes of depressive disorder which are secondary to heavy consumption of alcohol).

Diagnostic guidelines

The diagnosis requires that genuine damage should have been caused to the mental or physical health of the user.

Harmful patterns of use are mostly criticized by others and are frequently associated with adverse social consequences of various kinds. The actuality that a pattern of use or any particular substance is disapproved of by another person or by the culture, or leading to socially negative outcomes such as arrest or marital arguments does not in itself could be regarded evidence of harmful use.

Dependence syndrome

A bundle of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that earlier had greater value. A distinguishing feature of the dependence syndrome is the strong or overpowering desire to take psychoactive drugs, alcohol, or tobacco.

Diagnostic guidelines

According to ICD-10 a definite diagnosis of dependence should generally be made only if three or more of the following have been present together at a time during the previous year:

(a) individual has a strong desire or sense of compulsion to take the substance;

(b) facing difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;

(c) a withdrawal state of physiological nature when substance use has ceased or been reduced, evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the object of relieving or avoiding withdrawal symptoms;

(d) evidence of tolerance, meaning that increased doses of the psychoactive substance are required in order to achieve effects originally produced by at the lower;

(e) eventually neglecting alternative pleasures or interests because of psychoactive substance use, increased amount of time to obtain or take the substance or to recover from its effects;
(f) persistence with substance use despite clear evidence of overtly damaging consequences, such as harm to the liver through excessive drinking, depressive mood states ensuing to periods of heavy substance use, or drug-related impairment of cognitive functions; attempt should be made to determine that the user was actually, or could be expected to be, conscious of the nature and extent of the harm.

Narrowing of the personal range of patterns of psychoactive substance use has also been described as a characteristic feature (e.g. a proclivity to drink alcoholic drinks in the same way on weekdays and weekends, regardless of social constraints that determine appropriate drinking behaviour).

It is a distinguishing feature of the dependence syndrome that either taking of psychoactive substance or a desire to take a particular substance should be present; the subjective awareness of compulsion to use drugs is mostly seen when the individual attempts to stop or control the substance use.

The dependence syndrome might prevail for a specific substance (e.g. tobacco), for a class of substances (e.g. opioid drugs), or for a wider range of several substances (individuals who feel a sense of compulsion regularly to use whatever drugs are available and who show distress, agitation, and/or physical signs of a withdrawal state upon sobreity).

Withdrawal state

A group of symptoms of unfixed pattern of clustering and severity occurring on absolute or relative withdrawal of a substance after repeated, and prolonged or high-dose, use of that substance. Onset and course of the withdrawal state are time-limited and are related to

the type of substance and the dose being used just before abstinence. The withdrawal state could also be complicated by convulsions sometimes**.**

Diagnostic guidelines

Withdrawal state is one of the indicators of dependence syndrome and the above mentioned diagnosis should also be considered.

Withdrawal state should be considered as the main diagnosis when it is the reason for referral and is sufficiently severe to require medical attention.

Physical symptoms may vary according to the substance being used. Psychological disturbances (e.g. anxiety, depression, sleep disorders) also constitute common features of withdrawal. In most cases, the patient is likely to report that withdrawal symptoms are relieved by further administration of the substance.

TERMS USED IN SUBSTANCE-RELATED DISORDERS [4]

Dependence: The repeated use of drug or chemical substance accompanied with or without physical dependence.

Abuse: Use of any drug usually by self-administration, in a manner that deviates from the approved social or medical purposes.

Misuse: It applies to drugs prescribed by physicians that are not used properly.

Addiction: The persisted and increased use of substance, the deprivation of the same gives rise to symptoms of distress, and an irresistible urge to use the agent again and again eventually leading to physical and mental deterioration.

Intoxication: A reversible syndrome that is caused by a specific substance affecting one or more of the following mental functions: memory, orientation, mood, judgement, behavioural, social or occupational functioning.

Withdrawal: A syndrome specifically related to a substance that occurs after stopping or reducing the amount of the drug or substance that has been used regularly over a long period. It is characterized by physiological signs and symptoms in addition to psychological changes, such as disturbances in thinking, feeling, and behaviour.

Tolerance: Phenomenon in which repeated administration of a given dose of drug produces decreased affect or increasingly larger doses are required in order to obtain the same effect produced with the original dose.

Cross- tolerance: Refers to the ability of one drug to be substituted for another, each of them usually producing the same physiological and psychological effect.

Neuroadaptation: Neurochemical or neuropsychological changes in the body that a result of repeated administration of the drug. Neuroadaptation accounts for tolerance.

Co-dependence: Refers to family members being affected by or influencing the behaviour of the substance abuser.

EPIDEMIOLOGY

A Study was conducted on prevalence patterns and familial aspects of substance use among adolescents in Northern India and it was concluded that prevalence of substance use was seen in 52.7% students belonging to age group 19 to 21 years.[5] It is estimated that, in India, by the time most boys reach ninth grade, 50% of them have tried at least one of the substance of the abuse nature.[6] Influence of peers and close contacts who use substances are usually responsible for initiating substance use in others as well.[1] Illicit drug use—which includes the abuse of illegal drugs and/or the misuse of prescription medications or household substances—is something many adolescents engage in occasionally, and a few might do on a regular basis. By the 12th grade, about half of adolescents have already misuse an illicit drug once. The most commonly used drug is

marijuana, but adolescents are able to find many harmful substances in the home, which might include prescription medications, glues, and aerosols.[7]

According to The National Institute of Drug Abuse (NIDA) and other agencies, such as the National Survey of Drug Use and Health (NSDUH), as of 2012, it was estimated that more than 22 million persons above the age of 12 years were classified as having a substance-related disorder.

In regard to age at first use, those who started to use drugs at an earlier age (14 years or younger) were more probable to become addicted as compared to those who started at a later age. Among adults 21years or older who first tried alcohol at age 14 or younger, 15 percent were classified as alcoholics compared with only 3 percent who first used alcohol at age 21 or older.

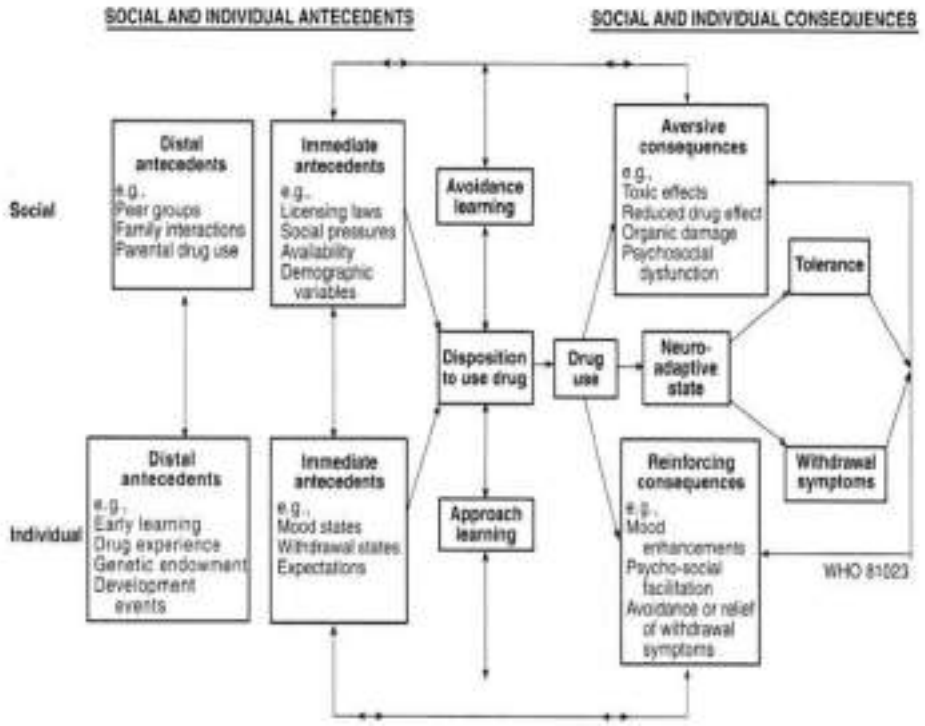
ETIOLOGY

The model of substance use disorders are based on the process in which multiple interacting factors influence drug-using behavior and the loss of judgment and in respect to make decisions about using a given drug. Furthermore, it has been suggested that different factors may be important at different stages of the drug taking process. Thus, drug availability, social acceptability, and peer pressures may be the major determinants and play and important role of initial experimentation with a drug, but other factors, such as personality and individual biology, probably are more important in how the effects of a given drug are perceived and the degree to which repeated drug use produces neural changes.[3]

It has been proposed that addiction is a “brain disease,” the processes that change voluntary drug-using behavior to compulsive drug use is related to the changes in the structure and neurochemistry of the brain of the drug user. Sufficient evidence that is available now indicates that such changes in relevant parts of the brain do occur.

Figure 1 below, illustrates how different factors might interact in the development of drug dependence. The first and foremost element is the drug-using behavior. The decision to use a drug is affected by one's immediate social and psychological situations as well as by the person's remote history. Use of the drug starts a sequence of consequences that can be rewarding or aversive for the individual and which, through a process of learning, can result in a greater or lesser likelihood that the drug-using behavior will be repeated. For some drugs, use of the substance, start the biological processes associated with tolerance, physical dependence, and sensitization. In turn, tolerance can further reduce some of the adverse effects of the drug, requiring the use of larger doses than before, which then in turn can intensify the development of physical dependence. Above a certain threshold, the aversive qualities of a withdrawal syndrome provide a distinct recurrent motive for further drug use to relieve the withdrawal symptoms. Sensitization of motivational systems can increase the prominence of drug-related stimuli.

Figure 1. World Health Organization schematic model of drug use dependence. (from Edwards G, Arif A, Hodgson R. Nomenclature and classification of drug- and alcohol-related problems. A WHO memorandum. Bull WHO. 1981;59:225.)



Psychodynamic Factors

According to classical theories, substance abuse is regarded being equal to masturbatory experience (some heroin users describe the initial “rush” as similar to a prolonged sexual orgasm), a defence against anxious impulses, or embodiment of oral regression (i.e., dependency). Recent psychodynamic theories regard substance use as a reflection of disturbed ego functions (i.e., the inability to deal with reality). Individuals might self-medicate themselves with alcohol to control panic attacks, opioids to diminish anger, and amphetamines to alleviate depression. Some addicts have difficulty recognizing their inner emotional states, a condition called *alexithymia* (i.e., inability to find words to describe one’s feelings).

Learning and Conditioning. Drug use, whether it be occasional or compulsive, can be viewed as a behavior that is maintained by its consequences. Drugs can reinforce antecedent behaviors by terminating some noxious or aversive state including pain, anxiety, or depression. In certain social situations, the drug use, apart from its pharmacological effects, can be reinforcing if it results in special status or the approval by friends. Each drug use produces rapid positive reinforcement, either as a result of the rush (the drug-induced euphoria), alleviation of disturbed affects, alleviation of withdrawal symptoms, or any combination of the above mentioned effects. Some drugs may result in sensitizing the neural systems to the reinforcing effects of the drug. Eventually, the paraphernalia (needles, bottles, cigarette packs) and behaviors associated with substance use can become secondary reinforcers, as well as cues signalling availability of the substance, hence as a result in their presence, craving or a desire to experience the effects increases.

In addition to the operant reinforcement of drug-using and drug-seeking behaviors, other learning mechanisms also play a role in dependence and relapse. Opioid and alcohol withdrawal phenomena can be conditioned (in the Pavlovian or classic sense) to environmental or interoceptive stimuli. For a long period of time after withdrawal (from opioids, nicotine, or alcohol), the addict when is exposed to environmental stimuli previously linked with substance use or withdrawal may experience conditioned withdrawal, conditioned craving, or both. The increased feelings of craving might not be accompanied by symptoms of withdrawal. The most intensified craving is prompted by conditions associated with the availability or use of the substance, such as watching someone else use heroin or light a cigarette or being offered some drug by a friend or drinking alcohol etc. These learning and conditioning phenomena can be superimposed on any pre-existing psychopathology, but pre-existing difficulties are not necessary for the development of reinforced substance-seeking behavior.

Self-medication theories: These psychological approaches propose that a person uses drugs in order to fill a void in their emotional lives or as a means of fighting with the inner conflict. A person can also be using the drugs to find relief from physical or emotional pain.

A person might also use substances to avoid or blunt their negative or disturbing feelings. The underlying reason for the pain that is being medicated is usually attributed to trauma which might include adverse childhood experiences (ACES), sexual or violence trauma as an adult, or other experiences associated with post-traumatic stress.

Personality theories: Some theorists propose that certain people are more prone to addiction and have a so-called "addictive personality". Eysenck has discussed this in expression of a ***psychological resource model,*** which explains the habit of drug-taking is developed because the drug being used helps in attaining a certain motive that is related to the individual's personality profile (Eysenck, 1997). For such people, drug-taking behaviour - or, in more specific terms, "addiction" - holds benefits even though there are negative consequences that occur after some time.[8]

According to Eysenck, there are three major personality dimensions: P which stands for psychoticism, N which stands for neuroticism, and E which stands for extraversion (Eysenck & Eysenck, 1985). The psychoticism dimension refers to an underlying propensity to functional psychosis, which lies along a continuum from "altruistic" to "schizophrenic" (Eysenck, 1997).Some of the characteristic traits of this dimension include aggression, coldness, egocentricity, impersonality, and impulsivity. The neuroticism dimension takes into consideration a propensity towards emotional lability: some of the traits of neuroticism are moodiness, irritability, and anxiety. Genetic factors are also theorized to play an important role in determining these personality dimensions; studies have also shown that the major personality dimensions are highly heritable (Eley & Plomin, 1997; Eysenck, 1997).

In a research by IOM, 1996, which was a longitudinal studies including children, examined personality attributes that predict 'substance use at a later stage and it was found that, in general, adolescents who are more rebellious and tend to have less conventional attitudes are more likely to drink, smoke, and use other illicit drugs (Institute of Medicine, 1996).

Rational choice theories: Another group of theories examined the problem of 'why people voluntarily engage in self-destructive behaviour' (Elster & Skog, 1999).One of the main elements of drug dependence is the fact that the individuals have impaired control over their use of the substance. This may manifest itself in further continued use despite a desire to reduce or stop use of the drug, to use greater amounts of the drug than intended, or to use the drug for longer periods of time than intended (American Psychiatric Association, 1994). This difficulty may be greater in certain contexts - for example, if an alcohol-dependent person has not had a drink for some time and walks past a bar, he would have a stronger craving to drink.

Some theorists argue that dependant drug users do make rational choices sometimes in their continued usage of drugs. These theories aim to explain how rational people become "knowingly trapped in a consumption pattern and once they realise that their current lifestyle is actually suboptimal (i.e. not the best thing), still continue to act the same way" (Skog, 1999).[8]

Genetic Factors

Strong evidence from studies of twins, adoptees, and siblings brought up separately indicates that alcohol abuse has a genetic component.

Several family studies on alcohol use disorders indicated that such disorders are probable to cluster in families (Kendler, Davis, & Kessler, 1997;Merikangas, 1990; Merikangas et al., 1998[9-11]).In another study by Merikangas et al., 1998, over one-third (36%) of the relatives of persons with an alcohol use disorder were also diagnosed with an alcohol use disorder (abuse or dependence), compared to 15% of the

relatives of controls.[11] Similar aggregates has been found for other drug use disorders as well (Bierut et al., 1998[12]; Merikangas et al., 1998[11]). Among persons who used cannabis predominantly, 13% of relatives of theirs also had a cannabis use disorder, compared to that of 2.4% of controls' relatives. The comparative rates for opiates were 10%vs. 0.4% and, for cocaine, 7.5% vs. 0.8% (Merikangas et al., 1998).[11]

Neurochemical Factors

As opioids act on opioid receptors, person with too little endogenous opioid activity (e.g., low concentrations of endorphins) or with too much activity of an endogenous opioid antagonist may be at risk for developing opioid dependence consequently.

Opiate drugs act as agonists at three major opiate receptor subtypes; μ (mu), δ(delta), and κ (kappa). The mu receptor appears to be the subtype important for the reinforcing effects of opiate drugs (Altman et al., 1996[13]; Di Chiara & North, 1992[14]. Mu receptors are largely located on cell bodies of dopamine neurons in the ventral tegmental area (VTA), the origin of the mesolimbic dopamine system; and on neurons in the basal forebrain, particularly the nucleus accumbens (Altman et al., 1996; Di Chiara & North, 1992)[13-14]. According to Altman et al., 1996, Delta opiate receptors may be important for the potentiation of the control of reinforcers over individual's behaviour. There is evidence that kappa opiate receptors are involved in the aversive effects associated with withdrawal symptoms of opiates[13].

The major neurotransmitters which might be possibly contribute to developing substance abuse and substance dependence are the opioid, catecholamine (particularly dopamine), and γ-aminobutyric acid (GABA) systems.

Alcohol has numerous primary targets of action, and identifying the mechanisms of action is a difficult task. Acute alcohol intake leads to increases in inhibitory transmission at gamma-amino-butyric acid

(GABA-A) channels, increased serotonin (5HT-3) function, dopamine release and transmission at opiate receptors, and a reduction of excitatory transmission at the NMDA subtype of the glutamate receptor (Altman et al., 1996[13]; Markou, Kosten, & Koch, 1998).[15]

ATTRIBUTIONAL STYLE

Attributional style refers to the habitual manner in which individuals allot causes of negative life events (Seligman, Abramson, Semmel, & von Baeyer, 1979).[17]

Attributional style is described across three dimensions: (1) internality – which means the degree to which an individual perceives themselves to be at fault for the occurrence of negative events; (2) stability – the degree to which the attributed cause of negative events persist over time; and (3) globality – the degree to which the attributed cause of negative life events impacts other situations as well (Peterson et al., 1982[18]; Seligman et al., 1979).[19]

People tend to overestimate the role of personal factors and overlook the impact of situations; people make a mistake, termed as the fundamental attribution error. This error is very closely related to another attributional tendency, the correspondence bias, which occurs when people attribute behaviors to other people's internal characteristics, even in heavily constrained situations.[17]

One type of attributional bias is that when individuals are too quick to attribute the behavior of other people to something personal about them rather than to something about their situation. This demonstrates general human tendency of underestimating how important the social situation really is in determining people's behavior. This bias posits in two ways. First, individuals are more likely to make strong personal attributions to account for the behavior that people observe others engaging in. When they tend to overestimate the role of personal factors and overlook the impact of situations, they are make a mistake termed as **fundamental attribution error**. This error is very closely related to another attributional tendency, the **correspondence bias**,

which occurs when people attribute behaviors to certain people's internal characteristics, even in the presence of heavily constrained situations.

MOTIVATIONAL NEEDS

According to Kast and Rosenzweig 1985, motive can be defined as what prompts a person to act in a certain way or at least develop an inclination for specific behaviour.[21]another definition by Yorks defines "Motivation" as those forces within an individual that push or propel him to satisfy basic needs or wants (Yorks1976) [22]. Maslow also stated that "Only unsatisfied needs provide the source of motivation; a satisfied need creates no tension and therefore no motivation" [23]. Commonly, three qualities are included in almost all the definitions of motivation: (1) it is a presumed internal force, (2) it helps in energizing the individual for action, and (3) it determines the direction of action (Rusel1971) [24]. Vrom defines motivation as a process governing choices made by persons among alternative forms of voluntary activity (Hamner and Organ 1978).[25]

McClelland has proposed a theory of motivation that is closely associated with learning concepts. The theory proposes that when a person has a strong need, it's eventual effect is to motivate the person to use certain behaviour which leads to satisfaction of that need. The main theme of McClelland's theory is that needs are learned through coping with one's environment. Since needs are learned, behaviour which is rewarded tends to recur at a higher frequency (again and again) (Gibson, IvancevichandDonely,1979)[26] .

There are three needs proposed by McClelland: nAch, nPow and nAff.
The need for achievement also known as nAch involves the individual's desire to independently master objects, ideas and other people, and to increase one's self-esteem through the exercise of one's research results. McClelland proposed a descriptive set of factors which reflect a high need for achievement.

These include:

1. Achievers tend to like the situations in which they could take personal responsibility for finding solutions to problems.
2. Achievers tend mostly to set moderate achievement goals and take "calculated risks" in order to succeed.
3. Achievers desire concrete feedback about how well they are doing, or their performance over the task(McCllelandandJohnson,1984)[27]

McClelland (1961)[28]described the need for power (nPow) as a concern with the means of influencing a person.

In a study by Lussier and Achua (2007; 2012)[29-30] they defined nPow as seeking positional authority and an unconscious concern of influencing others. Daft (2008) has defined the nPow as an eagerness to control or to have domination, authority and responsibility of others.[31]

There are two types of prevalent nPow namely- personal and institutional. People who need personal power wants to direct others and have direct power over others. This is often seen as undesirable as they look forward only for their own goals regardless of the shared benefits with other individuals. On the other hand, people with a high need for institutional power seek to achieve collective goals and are also concerned about other people's benefit as well.

McClelland (1961)[28] claimed affiliation is establishing, continuing or restoring a positive emotional relationship with another person. Need for affiliation is expressed as the passion to form close relationships, avoid conflicts and build warm friendships (Lussier & Achua, 2007; 2012)[29-30].

People with high need for affiliation find opportunities to create and maintain harmonious relationships with others. These people are more interested in building warm relations with other, diluting conflicts rather than winning arguments. They might not be able to be an effective leader as the need to be liked might affect their decision-making and their objectivity. Notwithstanding the positive side, people with high

need for affiliation play the role of peacemakers in the group and are important for maintaining harmony and teamwork. They respond best in a co-operative environment.

David Mc Clelland (1961) identified three types of basic motivating needs

1) Need for Achievement
2) Need for power
3) Need for Affiliation

People with strong achievement need like situations in which they can take personal responsibility or attribute the success for solving problems to themselves. They tend to take moderate risks and desire feedback concerning their performances.

On the other hand the need for affiliation reflects a desire to interact socially with other people. Such an individual is concerned about the quality of interpersonal relationships.

Whereas the individual with high need for power concentrates on obtaining, exercising power and authority over others. He is concerned with influencing others and winning arguments as well as taking credits for the same.[32]

PARENTAL RELATIONSHIP

Family relations and their influence on substance use can be viewed either in terms of connectedness or conflict [33]. Increase in either parent to parent conflict, or parent to offspring conflict, has been shown to increase the risk of developing a substance use disorder [34]. The level of family bonding and support by parents to their offspring might play a important role and are a predictor of alcoholism and drug use amongst the youth [33]. On the other hand favourable family bonds or relationships, family environment may reduce the likelihood of substance use problems, even amongst those individuals who have prevailing personality problems [35].

Substance use in most of the cases is associated with child abuse and domestic violence. It also is a leading contributor to marital dissatisfaction, family break- ups, and rejection of family members. The importance of the family in understanding alcohol and drug use and abuse is underlined by these highly destructive consequences of alcoholism and drug dependency on the abuser and the family (Gutierres, Russo, & Urbanski, 1994) [36]; McCrady, Epstein, & Kahler, 1998)[37].

Copello and Orford (2002) [38] discussed that literature strongly supports the findings that families are important stakeholders (promoters) who both facilitate the process of change and benefit from the improvement of an addiction problem (rehabilitation process) and also help in relapse prevention. They concluded that there are considerable benefits to acknowledging and capitalizing on the role of families with respect to getting substance abusers into treatment, maintaining their participation, improving their substance use related outcomes, and reducing negative impact and harm to the family including children. Their conclusion is not applicable in the cases where family members are not present, for this acts as a barrier to the extension of treatment routinely.

TYPES OF CONFLICT

The onset of substance abuse is frequently associated with stress and may be precipitated by family disruptions, control or management issues, or losses of facilities or family members (Bennett, 1995)[39]. Accordingly, in various studies it has been well established that family members often play a central or major role in the course of alcohol or drug addiction (Liddle & Dakof, 1995[40-44];Margolis & Zweben, 1998;Moore & Finkelstein, 2001; Moos, Finney, & Cronkite, 1990;Noel, Stout, & Malloy, 1993; O'Farrell & Fals-Stewart, 2000)and its treatment (Edwards & Steinglass, 1995[45]; Stanton & Shadish, 1997[46].This role has both negative and positive implications for treatment and outcomes.

Alcohol abuse has been shown to be both a precipitant and consequence of marital stress, spousal abuse, and separation and divorce (Amato & Previti, 2003[47]; Halford & Osgarby, 1993[48]; Wilsnack, 1996[49]. Stressful marital interactions are associated with exacerbation of alcohol abuse and failed attempts at abstinence (Halford & Osgarby, 1993[48]; Kahler, McCrady, & Epstein, 2003[50]. Substance abusers often tend to marry or partner with other substance abusers of the same kind (McCrady & Epstein, 1995[51]. Research indicates that discrepancy in substance use by couples has a relationwith lower marital quality and higher marital stress (Fals-Stewart, Birchler, & O'Farrell, 1999) [52]; Mudar, Leonard, & Soltysinski, 2001[53]; Wilsnack & Wilsnack, 1993[54].

Substance abuse causes conflict among family members. Some members may be jealous because the addict is getting so much of the attention. Spouses of addicts may become resentful of having to shoulder additional responsibility or cover up for their spouse's addiction. Children may assume unhealthy roles in the family to compensate for the substance abuser's inability to provide proper care and guidance.

Interpersonal stressors are attributed by many as the one of the most severe/crucial forms of stress and can eventually affect an individual's cognition and behavior. Maladaptive drug and alcohol use is a well-known precipitant and cause of interpersonal stress. In the last past two decades, there have been many constant efforts to define the construct of interpersonal stress and the ways by which it contributes to substance use and abuse.

The construct of self-esteem comprises both explicit and implicit domains. Explicit self-esteem is consciously considered and manipulated by the individual, while implicit self-esteem is unconscious and automatic. (Dehart T, Tennen H, Armeli S, et al) [55]. Although both are formed through early interactions with significant others, they are dissociable in many ways or could also be attributed to other factors

except social interactions with others. Implicit self-esteem develops at an early age and remains relatively constant and automatic over time while on the other hand explicit self-esteem may change based on dynamic interpersonal interactions (Dehart T, Pelham B, Tennen H)[56].

Studies have shown that there is prevalence of drug abuse in adolescents and young adults but there are few studies assessing the types of conflicts in these users, attributional bias and motivational needs. Further research is needed into the area of finding out the types of conflicts including parental conflicts, attributional bias and motivational needs in order to plan with the family based interventions.

AIMS & OBJECTIVES

1. To compare the parental relationship of young adults with and without SUD.
2. To compare the internal, personal and situation attributional bias in young adults with and SUD.
3. To compare the motivational needs of young adults with and without SUD.
4. To compare the types of conflicts in young adults with and without SUD.

REVIEW OF LITERATURE

A study on Coping via substance use, internal attribution bias, and their depressive interplay, enquired if internal attribution bias accompanied with a tendency to use drugs and/or alcohol to cope predicts increases in depression and daily-levels of general negative affectivity, sadness, and hostility. Results showed that substance use to cope, predicted increased depression among individuals with high-level of internal attribution bias. Further, it was also seen that coping through substance use moderated the relationship between internal attribution bias and daily-level sadness, which resulted in sadness being highest among individuals with a high internal attribution bias accompanied with greater levels of coping through substance use.[57]

Research investigating self-relevant attributions or personalizing bias and coping with drugs or alcohol remains limited; however, there is evidence of a positive association between internal attributional style and illicit drug use (Burnett et al., 2013).[58]

Kingree, Sullivan & Thompson (1999)[59] looked into the attributions made by individuals with substance abuse problems who enrolled themselves in a 12 step residential treatment program, regarding the causes of their addiction. Participants were assessed at admission and were then were again assessed at follow-up two months later, which was halfway through the program. To assess participant's attributions on the development of their addiction, they were given a questionnaire to assess the extent to which they believed different factors played a causal role in their drug use or substance addiction. The factors were coded in three spheres either as personal (e.g. low willpower), parental (e.g. insufficient love from parents) or societal (e.g. lack of jobs in community). They were assessed also for symptoms of depression and whether or not they were able to complete the program. At both times points, participants were found to attribute mostly to personal causes. At the two-month follow up, there was an increase in personal attribution and a decrease in societal attribution, and parental remained

unchanged. In this experiment, personal causes can be seen as internal attributions, while societal and parental can be seen as external attributions. Concluding that individuals tend to attribute more to personal causes or have a internal attribution.

Heider's (1958)[60] theory was later added to by Weiner (1985). In his theory of achievement, Weiner (1985) [61] argued that in the event of a success or failure, individuals would make three different attributions regarding its causality or why a certain phenomenon took place. The individual would either make an internal or external attribution, deciding if it was them who caused the success/failure or an artefact of the situation; an attribution on stability would then also could be made, focusing on whether this cause would be stable or unstable (changing) over time, eventually being followed by a judgement on whether this outcome would be global or specific, referring to how generalised the event would be i.e. whether it would persist across situations or be specific to only one situation.

Following on from Weiner's (1985) [61] model, in relation to addiction, Marlatt & Gordon (1980, 1985) [62][63] suggested a certain pattern of attribution within this model would be most likely to promote a relapse in substance use. They argued a that there exists a combination of internal, stable and global attributions, contributing to maladaptive thought patterns concerning addiction, promoting relapse; this pattern was termed as the abstinence violation effect (AVE). In this framework, it could be assumed that after a lapse in abstinence, this combination of internal-stable- global attributions would result in an individual to believe that the lapse was their own fault (internal), as opposed to being able to attribute it to the situation, due to a factor likely to endure or prevail over a period time (e.g. a trait-like disposition), that the event will likely again take place in similar situations (stable) and would also probably generalise to other cues, such as other drugs (global). One can see how such bleak attributions about themselves and regarding their reactions to future exposure to drugs may lead an individual to

relapse rather than returning to abstinence, possibly believing fighting the addiction to be a pointless battle, as they tend to make personal attributions hence feeling helpless and demotivated.

Weiner (1985, 1995)[61][64] argued that when people view an already stigmatised individual, observers will make a set of attributions in relation to the controllability and the onset and offset of the problem, which will in turn all affect how much help will be offered to the individual or to what extent will he be helped in his journey about the existing problem. It was asserted if the illness onset and behaviours resulting from the stigmatized illness, is believed to be uncontrollable eg: being a result of genetic cause, the observer will be more willing to help the afflicted; on the other hand, if the problem is seen as being in control of the individual, observers in the public are unlikely or less likely to help, believing the individual should be able to help themselves, believed as having a control over the situation. Similarly, in relation to illness offset, if an outside observer sees recovery from the illness as something within the individual's control, they as a result feel angry that the individual is not helping themselves, possibly seeing them as lazy or lacking motivation and hence might withhold help. These kinds of attribution processes are prominently noticed in relation to attribution processes concerning substance abuse and other mental health issues, where individuals are often believed to be the cause of their own problems, as if they brought the illness on themselves or caused it themselves to happen and could recover on their own if they wanted to or are motivated to do so.

Corrigan, Kawahara and O'Shaughnessy (2009)[65] assessed the role of public stigma on mental illness and substance abuse; participants were given to read vignettes about individuals diagnosed with either a mental illness for example schizophrenia or depression, a substance abuse problem or a physical disorder requiring a wheelchair (control condition). Participants were then questioned about their attributions towards the individual depicted in the read vignette on the extent to

which they saw the individual as responsible for their prevailing condition, able to overcome problems related to it, whether they should receive help from the community for their condition and whether they were supposed to be given assistance at work. Also, the participants were inquired about the extent to which they saw the individual as dangerous, frightening and as someone to avoid. Findings revealed that individuals having substance abuse problems were seen as having significantly more responsibility over their illness, were regarded as being more able to overcome their illness and were also perceived as more dangerous and frightening than those with a mental illness or in a wheelchair. These attributions about the onset, offset and controllability of substance abuse problems can be seen to have affected participants other responses as well, where those with substance use problems were found to be seen as being the people who were least worthy of help and most likely to be avoided, as compared to those with mental health issues or in a wheelchair.

While internal attributions following a relapse may lead an individual to feelings of guilt and shame and encourage self-medicating through substance use, internal attributions during abstinence may instead make an individual feel empowered and proud of their own success in abstinence. Through this conflicting evidence, one may conclude that while attributional processes play a large role in determining the course of an addiction, the direction of cognitions in relation to these attributions will ultimately play a larger role. To promote successful recovery from an addiction, as suggested by Larimer et al. (1999)[66] a process of cognitive restructuring may be appropriate, with different types of attributions being encouraged depending upon what stage the person is in, in their recovery.

Many people in active addiction reported their feelings as they are “worthless” human beings, indicating an almost total collapse of self-esteem or very low self-esteem. This eventually seems to reinforce the

urge to use drugs and alcohol to suppress the emotional pain of feeling worthless due to decreased self-esteem.

In another research investigating self-relevant attributions and coping with drugs or alcohol remains limited; however, there is evidence of a positive association between internal attributional style and illicit drug use.[57]

Empirical studies have further suggests that rigidity in attributional style can result in greater emotional distress over time as a function of coping-response invariability. Compas and colleagues (1988) in their study reported that causal attributions can become increasingly persistent when persons respond to a repeated stressor over a long period of time, and that invariance of one's coping methods is positively correlated with negative affectivity. In light of these findings, it can be concluded that individuals with an internal attribution bias are more vulnerable to experiencing apparently different stressors in a similar fashion (e.g., thoughts of being at fault or inadequate), which may become problematic if such persons also engage in substance use to regulate themselves.

In a prospective Study of Familial Conflict, Psychological Stress, and the Development of Substance Use Disorders in Adolescence showed that conflicts in the family were significantly associated with the higher risk of substance use disorders during adolescence, and 30% of this effect was due to higher levels of externalizing problems. Exposure to familial conflict at an early time in life increases the risk of substance use disorders during late adolescence and emerging adulthood.[67]

In several studies it has been concluded that a child's family environment has been found as one of the most significant influences on a variety of subsequent behavioral outcomes, including substance use problems in adolescence (Bray et al., 2001) [68]Johnson and Pandina, 1991[69]; Nation and Heflinger, 2006[70].

In a large scientific research study, examining the relationship between adversity in childhood and behavioral outcomes later in life, the Adverse Childhood Experiences (ACE) study investigated the effects of abuse, neglect, and household dysfunction on substance use problems in adolescence and adulthood. Using retrospective reports, findings showed that exposure to certain adverse family environments was significantly and positively associated with alcohol use initiation in early adolescence (prior to age 14) and in mid-adolescence (between ages 15 and 17) (Dube et al., 2006), alcohol abuse in adulthood (Dube et al., 2002)[73] and illicit drug use problems in adolescence (Dube et al., 2003)[74]. These studies also found a classified relationship between adverse childhood experiences and substance use problems, in that a higher number of adverse childhood experiences was associated with an increased risk for alcohol and illicit drug problems.

Family environments with high levels of adversity, including violence, stress, parental drug use, ineffective communication and discipline, and poor sibling relationships, have been linked to increased and vulnerable adolescent drug use.[75][76]

In a study on Adverse childhood experiences and personal alcohol abuse as an adult, A questionnaire about childhood abuse, parental alcoholism and family dysfunction while growing up was completed by adult HMO members in order to retrospectively assess the independent relationship of eight ACE cases to the risk of adult alcohol abuse. Each of the individual ACE cases were found to be associated with a higher risk alcohol abuse as an adult. Compared to persons with no ACEs, the risk of heavy drinking, self-reported alcoholism, and marrying an alcoholic were increased twofold to fourfold by the presence of multiple ACEs, even if parental alcoholism was present. Prevention of ACEs and treatment of persons affected by them may reduce the chance of occurrence of adult alcohol problems.[69-70]

The effects of substance abuse usually are seen to extend beyond the nuclear family. Extended family members may also experience feelings

of abandonment, anxiety, fear, anger, concern, embarrassment, or guilt; they might desire to ignore or cut ties with the person abusing substances or having substance use problems. Some family members also reported a feeling of need for legal protection from the person abusing substances. On top of this, the effects on families may continue for upcoming generations. Intergenerational effects of substance abuse can also be seen to have a negative impact on role modeling, trust, and concepts of normative behavior, which can eventually result in damaging relationships between generations. For example, a child who stays with a parent who abuses substances may grow up to be an overprotective and controlling parent who does not allow his or her children sufficient autonomy.[71]

Reilly (1992) [72] describes several characteristic patterns of family interaction, one or more of which are expected to be present in a family that includes parents or children abusing alcohol or illicit drugs:

1. Negativism. Any communication that occurring among family members is negative, taken in the form of complaints, criticism, and other expressions of displeasure. The overall mood of the household is markedly downbeat, and positive behavior is ignored automatically. In these types of families, the only way to get attention or enliven the situation is to create a crisis. This negativity may as a result, serve to reinforce the substance abuse.

2. Parental inconsistency. Rule setting is regarded erratic, enforcement as inconsistent, and resulting family structure is inadequate. Children become confused because they are unable to figure out the boundaries of right and wrong. This results in their bad behavior in the hope of getting their parents to set clearly defined boundaries. Without known limits, children cannot predict parental responses in certain situations and adjust their behavior accordingly. These inconsistencies are inclined to be present regardless of whether the person abusing substances is a parent or child and they create a sense of confusion—a key factor—in the children.

3. Parental denial. Despite obvious warning signs, the parental stance or denial is seen as: (1) “What drug/alcohol problem? We don’t see any drug problem!” or (2) after authorities intervene: “You are wrong! My child does not have a drug problem!”

4. Miscarried expression of anger. Children or parents who begrudge their emotionally deprived home and are also at the same time afraid to express their outrage use drug abuse as one way in order to manage their repressed anger.

5. Self-medication. Either a parent or child will use drugs or alcohol to cope with intolerable thoughts or feelings that might be difficult for the individual to cope with, such as severe anxiety or depression.

6. Unrealistic parental expectations. If parental expectations are unrealistic or impractical, children can tend to excuse themselves from all future expectations by saying, “You can’t expect anything of me—I’m just a pothead/speed freak/junkie.” Alternatively, they might also work to overachieve, with a persistent feeling that no matter what they do it will never be good enough, or they may joke and clown to deflect the pain or may withdraw and isolate themselves to side-step the pain. If parent’s expectations are too low, and children are told throughout their youth that they will certainly fail someday and never succeed, they tend to conform their behavior to their parents’ predictions, unless meaningful adults intervene with healthy, positive, and supportive messages in the child’s life.

If a child or adolescent abuses substances, it is very much likely that any household could experience conflict and continual crisis. Hoffmann (1995) [77] in his study discovered that increased adolescent living with divorced and stepparent became less attached with the family which resulted in more frequent marijuana use. With fewer ties to the family and increased family gap, the likelihood of the adolescent forming attachments to peers who abuse substances increases. Weaker ties to the family and stronger ones to peers using drugs increase the chances of the adolescent starting to use marijuana or increasing marijuana use respectively.

Research over the last two decades has shown the authoritarian parental style to be associated with the offspring's greater use of alcohol (Schucksmith et al., 1997) [78] and other substances (Aguilar et al., 2004) [79]; Garc´ıa & Gracia, 2009) [80], as compared to authoritative parents who employ authoritative parenting style.

With regard to the authoritarian parental style, Patock-Peckham & Morgan-Lopez, 2009b, have argued that the parenting style is related to higher levels of alcohol use, as it eventually increases neurotic symptoms and pathological reasons for drinking [81]. Moreover, in another study they found out that having an authoritarian father makes the child feel overprotected, which results in the child having lower self-esteem and a consequent increase in depressive symptomatology and alcohol-related problems in males (Patock-Peckham & Morgan-Lopez, 2009a).[82]

Schucksmith, Glendinning, & Hendry, 1997, concluded that it would seem that when control is overly strict and limits are enforced with too much constraint, behavioral problems such as substance use may emerge in children as the result.[83]

According to Bean, Barber, and Crane 2006, parental psychological control can be understood as parental interference or manipulation of children's emotions, feelings, and thoughts through guilt induction, love withdrawal, shaming, manipulation of emotional security, and/or discounting children's perspective [84]. In a study by Rogers, Buchanan, and Winchell 2003, it was connoted that instead of regulating adolescent behavior (i.e., behavioral control), psychological control "communicates that the adolescent's thoughts, emotions, feelings, and/or even the adolescent are unacceptable"[85]. A study by Costa et al. 2019, showed that a high level of parental psychological control erode adolescent efficacy and autonomy efforts which leads to unhealthy self-concept formation and adjustment issues[86] which makes adolescents vulnerable to the development of risk behaviors including using tobacco, alcohol, and other substances (Kincaid et

al. 2011; Romm and Metzger 2018) [87,88] For example, Romm and Metzger (2018) in their study, found a positive relationship between parental psychological control and substance use among adolescents suffering from unhealthy psychological conditions.[88]

Diggs et al. (2017) [89] in his study demonstrated that parental factors (such as harsh parenting and parent–child communication) predicted subsequent adolescent substance use level, but they did not examine the effects of parental factors on the rate and pattern of changes in adolescent substance use.

In a study by Becoña E, Martínez Ú, Calafat A, et al, children of authoritarian parents were generally reported to have more substance use than the children of authoritative parents.[90]

In a study on family risk factors related to alcohol use consequences and poor adjustment in fraternity and sorority members where it explored the role of parent-child conflict. Parent-child conflict at baseline significantly predicted alcohol-related consequences 1 year later for all students. Father-child conflict was found to be a significantly better predictor for male students. While it was also seen that parent histories of problem drinking or heavy alcohol use did not account for this relationship hence a less appropriate predictor for the children's substance use.[91]

According to various studies by different authors, parenting styles and behaviors have been found to be related to both the onset and development of substance abuse among children and adolescents. Parent-youth conflict, harsh parenting (involving severe physical punishment or verbal reprimand), poor monitoring, ineffective control, permissiveness, and lack of parental warmth all have been related to increased substance abuse by youth (Griffin, Botvin, Scheier, Diaz, & Miller, 2000)[92] Kumpfer, Alvarado, & Whiteside, 2003[93];Lochman & Steen- hoven, 2002[94]; McGillicuddy, Rychtarik, Duquette, & Morsheimer, 2001[95]; Webb, Bray, Getz, & Adams, 2002[96]. Research

also indicated that different parenting styles of mothers and fathers both have differential effects on their children's inclination to use drugs (Baumrind, 1991)[97].

In a study by Thompson & Wilsnack, 1987, adolescents were found to use alcohol and other drugs to ease tension at home or as an act of rebellion against parental authority.[98]

Research provides evidence about the contention that stressful spousal or partner relationships act as a trigger for the desire to return to or continue the abuse of alcohol and other drugs (Sullivan, Wolk, & Hartmann, 1992)[99]. In a study is was found that poor communication and problem-solving, arguing, financial stressors, and nagging are often reported as a strong precursor to drug abuse. Resentment by the abuser towards efforts to intervene or control substance abuse behavior sometimes serves as a hint or signal to continue consumption (Wynne et al., 1996)[100].

In a study on the role of attributions in abstinence, lapse, and relapse following substance abuse treatment showed that people who abstained themselves, made increased internal, stable, and global attributions regarding their abstinence. Abstainers' attributions for their success in remaining abstinent tended to be similar to the attributions made by people who relapsed for their failure to remain abstinent.[101]

In one study where the social stress model of substance abuse was tested among a sample of urban adolescents, Rhodes and Jason (1990) found that poor family environments (i.e., poor parental relationships, a high degree of family problems) were significantly associated with a higher level of drug use.[102]

The use of substances is an attempt to compensate for vulnerabilities in the ego structure. Substance use, then, is motivated by an inability to regulate one's inner life and external behavior. Thus, psychoanalytic treatment assumes that insight obtained through the treatment process

results in the strengthening of internal mechanisms, which becomes evident by the establishment of external controls; in other words, the change process shifts from internal (intrapsychic) to external (behavioral, interpersonal). (Khantzian et al, 1990).[103]

A systematic review presented by Ryan, Jorm, and Lubman (2010)[104] focused that there were various parental factors that predicted the onset of adolescent drinking, which included parental modelling, parental monitoring and the quality of the parent–child relationship, with increased family conflict associated with both an earlier age of drinking (Shortt, Hutchinson, Chapman, & Toumbourou, 2007)[105] and increased levels of adolescent alcohol consumption (Bray, Adams, Getz, & Baer, 2001[106]; Mason, Hitchings, McMahon, & Spoth, 2007)[107].

In a study by Chilcoat and Anthony, 1996 it was seen that the severity of substance abuse in youth is related to parental monitoring and supervision; the less supportive and structured the family environment, the more severe the substance abuse, increasing the vulnerability towards the substance.[108]

De Hart et al. in his study reported that college students with low implicit self-esteem after having negative interpersonal experiences in the daytime, consumed more alcohol in the evening. It was also found that explicit self-esteem did not diminish the relation between interpersonal interactions and evening alcohol use. In fact, it was noticed that explicit self-esteem had no effect on the relation between implicit self-esteem and evening alcohol consumption [55]. Trait self-esteem was also noticed to moderate the association between negative encounters with romantic partners and alcohol consumption. Individuals with low trait self-esteem were observed to be drinking more on days when they experienced increased conflicts with their significant others; greater state self-esteem was related to narrowing this association [109]. The authors speculated that people with low trait

self-esteem consume alcohol as a means to regulate the acceptance needs that remained unfulfilled [109].

Leary (1956)[110] asserted that the interpersonal point of view can be considered the most crucial and functionally important dimension of personality, and that interpersonal behavior is that aspect of personality which accounts as the most functionally relevant aspect to the clinician.

Recent trends in therapy provide more prominent evidence of the clinical function ability of the interpersonal relations dimension. Trends including increased group therapy, family therapy, transactional therapy and others all stress highly on the value of treating the client in an environment where interpersonal behavior can be observed and modified within a natural (interpersonal) setting.

Patients with substance abuse are also vulnerable to experiencing significant interpersonal distress, and studies have shown that these patients' subjective (personal) perceptions of their social problems are fundamental to the diagnosis and treatment of alcohol problems. In conjugation with other variables, interpersonal distress can have a significant impact on the individual's quality of life (Reaney, Martin, & Speight, 2008)[111]. Further, such increased interpersonal distress may result in increased alcohol consumption (Lemke, Brennan, Schutte, & Moos, 2007)[112], and also play a part in relapse (Leach & Kranzler, 2013[113] Marlatt & Donovan, 2005).[114]

According to O'Connor et al, People who have increased amount of interpersonal guilt are often reported to suffer from psychological distress such as depression and anxiety[115] and they may also abuse alcohol and drugs to cope with their guilt-related feelings and ideas regarding the distress. O'Connor et al.[116] in their study reported upon common cognitions in their clinical work with people with substance use disorders such as: "To develop a successful life without drugs is to defy a parental dictate to be inadequate and out of control" and "To be happy, comfortable, and successful will make another family member (or members) feel inadequate and inferior, and thus will cause others'

unhappiness." Thus, excessive interpersonal guilt may be related strongly with substance use.

Kounenou noticed that increased self-esteem is the predictor of avoidance of drugs and narcotics.[117] Furthermore, Kahn in his study found that lack of self-esteem can be correlated with increase in likelihood or probability of some crimes and drug abuse.

Guglielmo et al. reported that low self-esteem is correlational to drug use.[118]

In another study by Feltis it was also reported that there existed a very strong negative correlation between trend of drug use and amount of self-esteem in adolescents, and children. Those whose self-esteem did not grow well or was decreased as compared to other children and adolescents, were more probable or vulnerable to consuming drugs.[119] Smart and Ogborne reported that youths under treatment for drug abuse had lower self-esteem.[120] Emery et al. found in her study that student's self-esteem (at home or at school) is reversely or inversely correlated with drug use (illegal substances and drugs), tobacco and alcohol, i.e., lower the self-esteem, higher the drug use.[121]

A number of other activities could be run after in an addiction like pattern, where an initially neutral activity becomes a consuming passion whose pursuit is experienced as a "necessity" as a result, despite potentially negative consequences of the activity.

In the palatinate of motivation for money, economists make mention of the hedonic treadmill to explain that how people's increasing greed is related with accumulating wealth (Kasser & Ryan, 1993)[122]. Adaptation processes following drug tolerance effects have been invoked to explain why acquired wealth often eventually results in increased (and unsatiated) motivation to amass or gather more money, even when doing so brings little or no happiness or satisfaction (Diener, Suh, Lucas, & Smith, 1999[123]; Kasser & Ryan, 1993[122]; Sirgy, 1998.[124]

In the study by Jones and Nisbett (1971), they reported that individuals who have the problem themselves, and observers who do not, make dispositional attributions of others or for other people.

According to the study by Bársonya et al, it was concluded that opiate dependent persons taking methadone maintenance treatment seemed to have lower needs of achievement and higher needs of affiliation as compared to non-user control persons. (Bársonya et al.(2013).[126]

On the other hand, the desire for warm and loving relationships and the need for get-togethers or affiliation with friends might be more important for the opioid dependents seeking treatment as compared to the control persons.
McClelland et al. (1972)[125] in his study found more affiliation and power notions but less achievement notions in marijuana and LSD users' narratives for TAT pictures. They conclude that drug use posits as a type of expression of personal power needs or rebellion for youth, which in the past had been expressed by heavy drinking and could still be observed among older men.

The warmth and comfort that drinking induces and the calmness it often brings to a drinking group may compensate for a sense of loss and ease the insecurities associated with an "absent" father. [127]

Following this psychodynamic theme, David McClelland and his colleagues in their 1972 book, named the drinking man, concluded that heavy drinkers were "obsessed with manly virtues" and have "real doubts about their efficacy as males."[125] McClelland used the Thematic Apperception Test (TAT) with university students and working-class men to obtain and rate their fantasies when under the influence of alcohol as compared to when sober. The men's fantasies were more likely found to have themes of power and domination when under the influence of alcohol. In the same way, men with heavy drinking histories were found to more likely have power fantasies than those who did not have a heavy drinking history. McClelland concluded

from his study that men drink in order to compensate for unconscious feelings of deficiency, negate feelings of intimacy and hence avoid responsibility. Alcohol abuse was concluded to be a means of asserting power and feeling like a “man”.

MATERIALS AND METHODS

Research Design: The present study employed the cross-sectional study design. The sample for the study group was collected from DMCH, Ludhiana and the sample for the control group was collected from the general population.

SOURCE OF DATA

Study was conducted on 50 SUD patients (25 having alcohol use disorder and 25 having opioid use disorder), admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College & Hospital and 50 healthy individuals as control group from general population.

METHOD OF COLLECTION OF DATA

SAMPLE COLLECTION- The study was conducted on of 50 SUD patients (25 patients with alcohol use disorder and 25 patients with opioid use disorder) admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College and Hospital and 50 healthy individuals as control group from 18 to 35 years of age from general population.

INCLUSION CRITERIA (study group)

- Patients having a diagnosis of any substance use disorder according to ICD 10.
- Age group between 18 to 35 years.
- Patients having SUD, admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College and Hospital.
- Patients willing to give informed consent.

EXCLUSION CRITERIA (study group)

- Patients with any major psychotic illness, developmental disability and intellectual disability.
- Patients not willing to give informed consent.

INCLUSION CRITERIA (control group)

- Healthy control group not having any major psychiatric illness.
- Individuals not having the diagnosis of any SUD.
- Age group between 18 to 35 years.
- Patients willing to give informed consent.

EXCLUSION CRITERIA (control group)

- Patients with any major psychotic illness, developmental disability and intellectual disability.
- Patients not willing to give informed consent.

METHODOLOGY

The study was conducted on 50 SUD patients (25 patients with alcohol use disorder and 25 patients with opioid use disorder), admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College, Ludhiana and 50 healthy individuals as control group from 18 to 35 years of age from general population. Informed consent was signed by the participants first, then Socio Demographic Performa was filled containing the basic information of the subject and they were evaluated for parental relationship using The Parent Adult-Child Relationship Questionnaire (PACQ), attributional bias using Internal, Personal and Situational Attribute Questionnaire (IPSAQ), motivational needs using Motivational Questionnaire and types of conflicts by administering Sacks Sentence Completion Test (SSCT).

TOOLS:

1. Socio-Demographic Performa
2. The Parent Adult-Child Relationship Questionnaire (PACQ)
3. Internal, Personal and Situational Attribute Questionnaire (IPSAQ)
4. Motivational Questionnaire
5. Sacks Sentence Completion Test (SSCT)

The Parent Adult-Child Relationship Questionnaire (PACQ) (Peisah, C., Brodaty, H., Luscombe, G., Kruk, J., & Anstey, K.) [128]
It is a short 26-item questionnaire that measures the familial relationship between parent and the adult child, measuring it from the adult child's point of view. It is divided into two subscales one assessing 'relationship with mother' (PACQM) having 13 items, and other assessing 'relationship with father' (PACQF) having13 items. The instrument can be self-administered and can be applied to both sexes.
There are two factors in relationship with mother and three factors in relationship with father namely: responsibility, regard and control.
For maternal relationship the regard factor consists of five items, and responsibility factor consists eight items.

For paternal relationship the regard factor consists of four items, responsibility factor consists of four items and control factor consists of five factors.

The *regard* factor coincides closely to similar concepts of attachment or care, and encompasses of filial gratitude or reciprocity and perceived closeness or compatibility (Cicerelli, 1983; Eisdorfer, 1991; Horl, 1989). The *responsibility* factor includes parental behaviours as well as the adult child's feelings of guilt, burden and protectiveness, and has elements of parentification and the desire to compensate for the parent's past suffering (Boszormenyi-Nagy & Spark, 1984; Whittick, 1989). The *control* factor (relevant for fathers only) is corresponding to that identified in analyses of earlier relationships (Parker, 1983; Siegelman & Roe, 1979) but without the protection element. This, together with the more positive skew of the factor, puts forward the possibility of a pathological entity, which may reflect the naturalistic evolution of parental power over the life cycle.

The internal consistency for the 'mother solution' was 0.87 for the *regard* factor and 0.82 for the *responsibility* factor as measured by Cronbach's alpha. The 'father solution' yielded a Cronbach's alpha of

0.86 for the *regard* factor, 0.74 for the *responsibility* factor and 0.87 for the *control* factor.

Scoring: Each item is scored as 0-3 points. The points for each item are added for each factor group and then for each subscale to get the total score for maternal and paternal relationship respectively and also for the total score for each factor.

Internal, Personal and Situational Attribute Questionnaire (IPSAQ) (Peter Kinderman and Prof. Richard P. Bentall).[129] It is a 32 item questionnaire items which describes16 positive and 16 negative social situations in the second person. It measures three types of attributes namely: internal attribution; external-personal attribution and external-situational attribution. Reliability statistics yielded Cronbach's alpha as follows for subscales-Positive-Internal = 0.717, Positive-Personal= 0.611, and Positive-Situational= 0.605; Negative-Internal = 0.732, Negative-Personal = 0.629, and Negative-Situational = 0.755; mean = 0.675. Reliability statistics (Cronbach's alpha), for two composite scores is for: EB= 0.719, PB= 0.761 respectively.

Scoring: For each item the respondent is required to write down a single, most probable, causal explanation for the situation described. The respondent is then required to categorize this cause as being either internal (something to do with the respondent), personal (something to do with another person or persons) or situational (something to do with circumstances or chance) by marking appropriate choice. Three positive and three negative subscale scores are then found out by summing the number of internal attributions, the number of personal attributions and the number of situational attributions chosen for both the positive and negative items.

Two cognitive bias scores are derived from the above six subscale scores. Externalizing Bias (EB) is calculated by subtracting the number of internal attributions for negative events from the number of internal attributions for positive events. A positive EB score therefore indicates

strong self-serving biases (that is, blaming oneself less for negative events than for positive events). Personalizing Bias (PB) indicates the proportion of external attributions for negative events which are personal as opposed to situational and is calculated by dividing the number of personal attributions by the sum of both personal and situational attributions for negative events. Hence a PB score of greater than 0.5 represents a greater tendency to use personal rather than situational external attributions for negative events.

Motivational Questionnaire (Junker 2001)[130] It is a 11 item short questionnaire which helps in determining whether the individual is motivated by achievement, power or affiliation needs, based on McClelland motivational theory. In each question, the test subjects tick mark only one of three types of needs. The external validity was verified by the experts and professors in a study, also its reliability was calculated in a pilot study (Cronbach's α=0.90). (Mojtaba Raeisi et al, 2012)

Scoring: Each need is scored as one and the highest number of score for that particular need determines the motivational need of the individual.

Sacks Sentence Completion Test (JM Sacks)[131] The test was designed to find out significant conflicts in four areas representative of adjustment. It was developed by Sacks and other psychologists. The four areas covered by the test are named as: Family, sex, interpersonal relationship and self- concept.

The family area includes three sets of attitudes, attitudes towards mother, father and family unit. Each has four incomplete open ended sentences. There are total 12 items in family area. The participant has to complete the sentences. Sex area includes attitude towards women and heterosexual relationship. There are four incomplete sentences in each area. The area representing interpersonal relationship includes attitude towards friends, acquaintances, superior persons at college/school/work, supervisors, co-workers. There are a total of 20

incomplete sentences in this area. Self-concept area involves guilt feelings, attitudes towards one's own abilities, past, future and aim. Overall 60 incomplete sentences are there in the test, which is supposed to be completed by the participant.

The reliability and validity of the test was determined by various psychologists who rated the degree of disturbance of a hundred subjects on the basis on their responses on the test. The psychiatrists who treated these subjects made independent ratings in terms of the degree of disturbance of each subject, based on their clinical impression. Correlation in the ratings of psychologists and psychiatrists revealed contingency co-efficient of 0.48 to 0.57 with standard error of 0.02 and 0.02 each. This indicates that the ratings of both psychologist and psychiatrist have significantly positive relationship. Thereafter interpretive summaries of subject's responses were submitted to psychiatrists where they rated their agreement on those clinical findings. 77% of the statements were rated in agreement of the clinical findings (Edwin, 1950).

A rating sheet has been proposed for the SSCT which clubs together, under each attitude, the four stimulus items and the participant's responses to them. A rating is then made of the subject's degree of disturbance on each item then in each subarea e.g. Attitude towards father (a sub area of family). The disturbance ratings are as follows:

1. Severely disturbed (rate2)
2. Mildly disturbed (rate 1)
3. No significant disturbance (rate 0)
4. Unknown insufficient evidence

STATISTICAL ANALYSIS:

Quantitative analysis was done. Data was described in terms of mean ± standard deviation (±SD), frequencies (number of cases) and relative frequencies (%age) as appropriate. Chi square test, t- test and ANOVA test were used for comparing different variables. A probability value (p-value) less than 0.05 was considered statistically significant. All

statistical calculations were done using SPSS (Statistical Package for the Social Science)- SPSS 21 version statistical program for Microsoft windows.

RESULTS AND OBSERVATIONS

TABLES AND FIGURES

Table 1: Distribution of Participants (patients with SUD and control group) in Terms of Age Groups (n=100)

	Group		Total
AGE RANGE	**Group A**	**Group B**	
18-23	3 (6%)	11 (22%)	14
24-29	18 (36%)	27 (54%)	45
30-35	29 (58%)	12 (24%)	41
Total	**50**	**50**	**100**

Figure 2: Distribution of Participants (patients with SUD) in Terms of Age Groups (n=50)

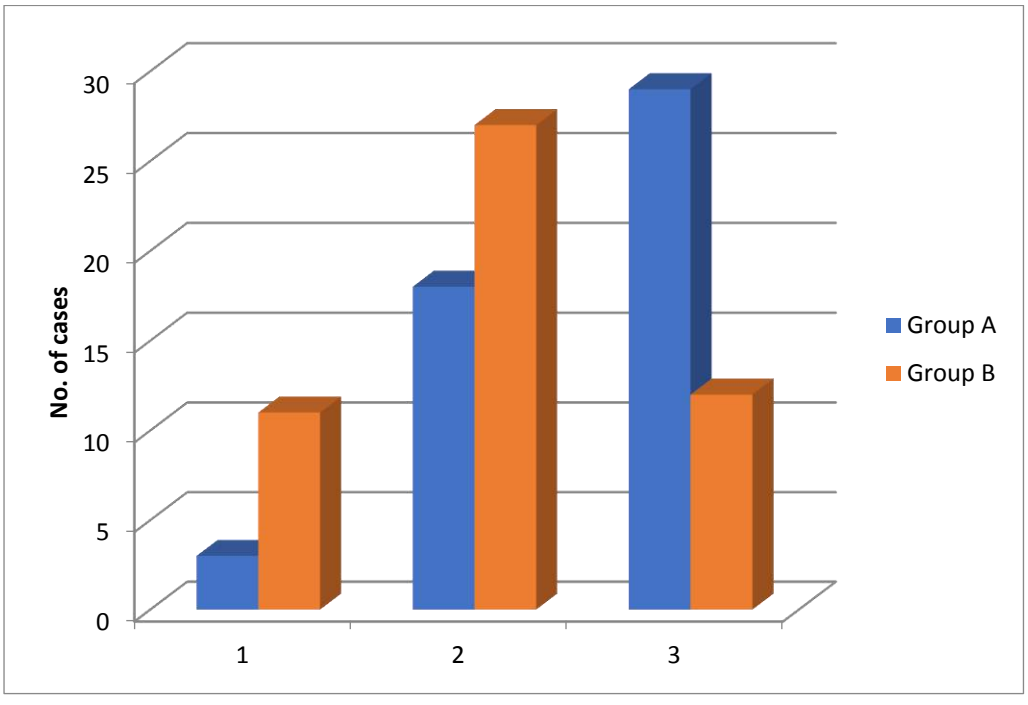


Table 2: Mean and SD of Participants (patients with SUD and control group) in terms of Age (Years) (n = 100)

	Group A		Group B		t	p-value
	Mean	**SD**	**Mean**	**SD**		
AGE	29.34	4.80	27.28	3.55	2.442	**0.016**

Figure 3: Mean and SD of Participants (patients with SUD and control group) in terms of Age (Years) (n = 100)

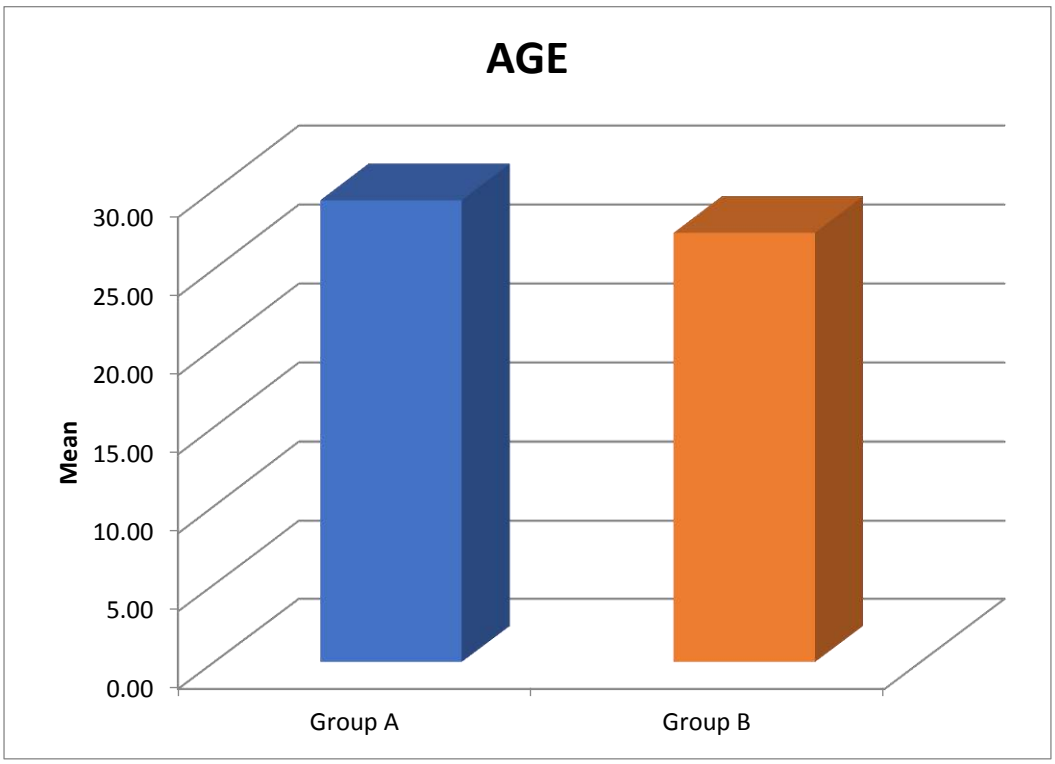


Table 3: Distribution of Participants (patients with SUD) in Terms of Drug use (n=50)

DRUG=O/A	Group	
	Group A	**Group B**
	0	**50**
A	25	0
O	25	0
Total	**50**	**50**

Figure 4: Distribution of Participants (patients with SUD) in Terms of Drug use (n=50)

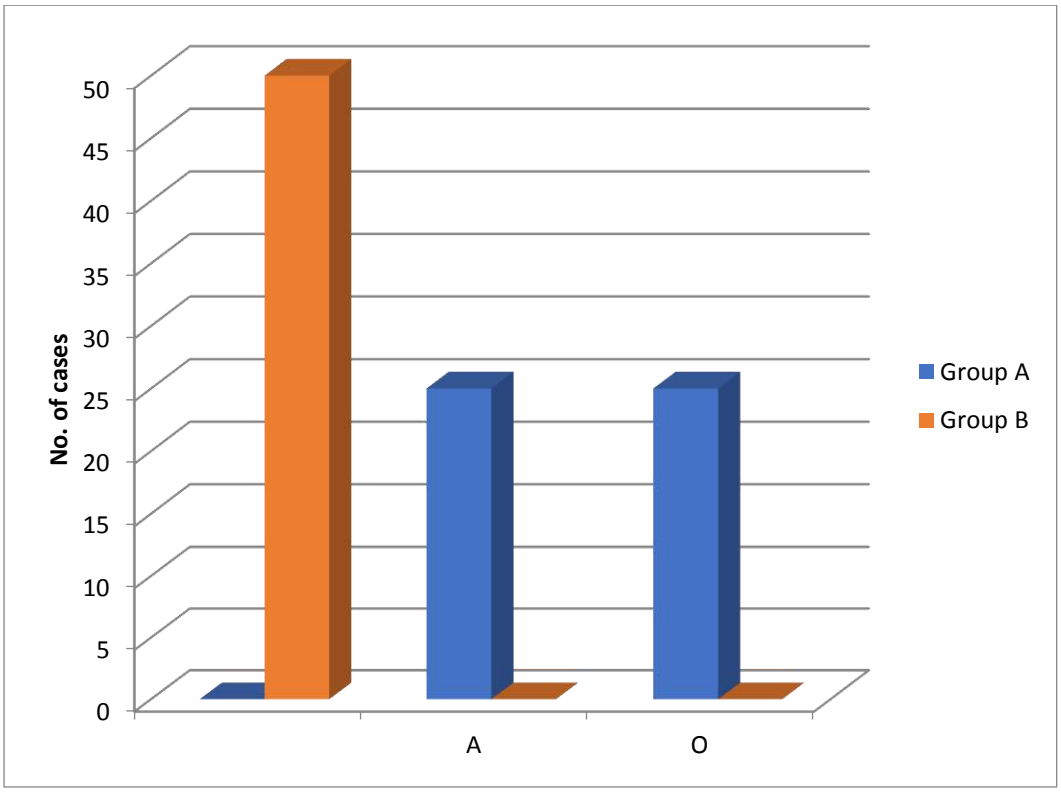


Table 4: Distribution of Participants (patients with SUD and control group) in Terms of rural/ urban (n=100)

RURAL/URBAN	Group	
	Group A	**Group B**
RURAL	12 (24%)	0 (0%)
URBAN	38 (76%)	50 (100%)
Total	**50**	**50**

Figure 5: Distribution of Participants (patients with SUD and control group) in Terms of rural/ urban (n=100)

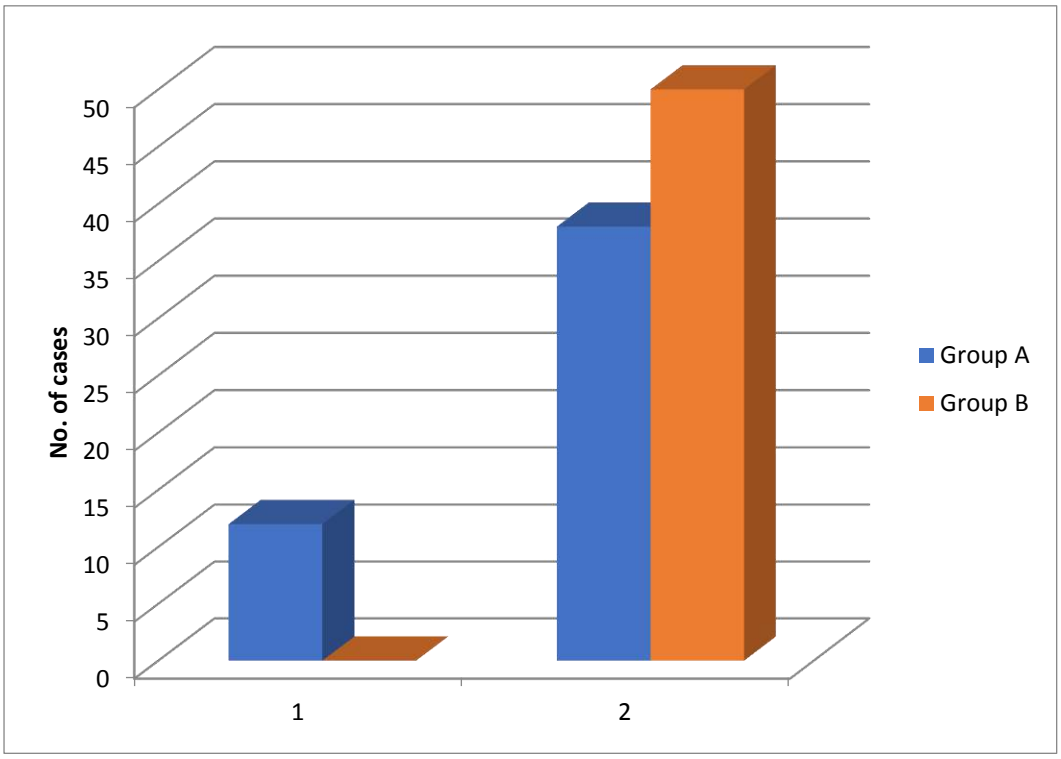


Table 5: Distribution of Participants (patients with SUD and control group) in Terms of family type (n=100)

FAMILY TYPE	Group		Total
	Group A	Group B	
JOINT	23 (46%)	6 (12%)	29
NUCLEAR	27 (54%)	44(88%)	71
Total	**50**	**50**	**100**

Figure 6: Distribution of Participants (patients with SUD and control group) in Terms of family type (n=100)

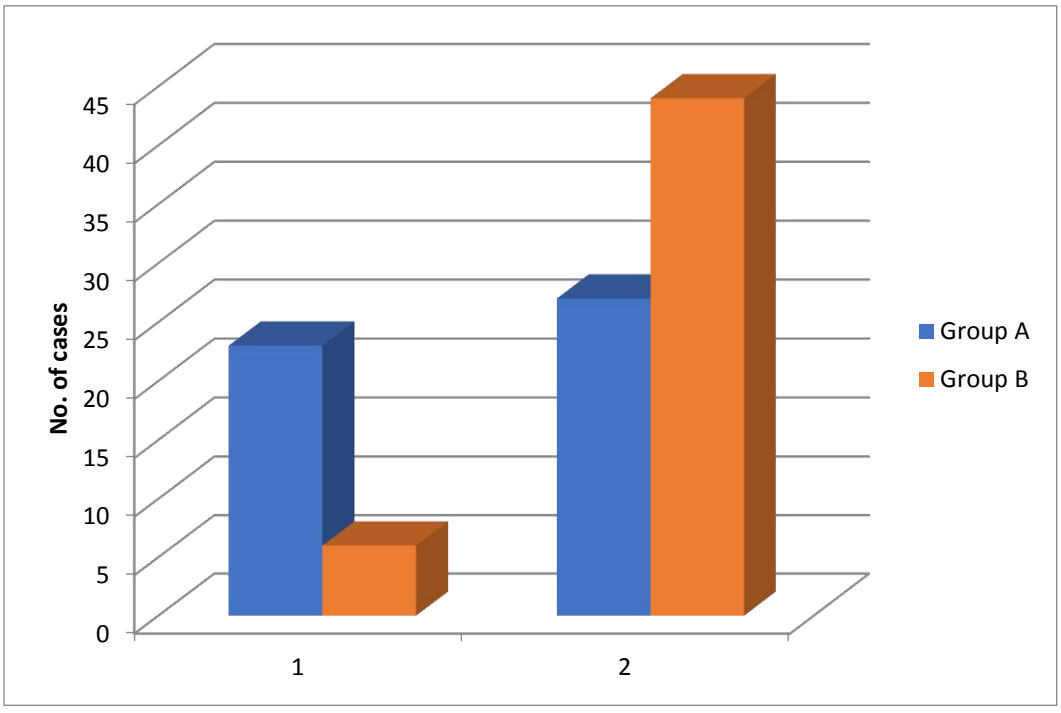


Table 6: Distribution of Participants (patients with SUD and control group) in Terms of marital status (n=100)

MARITAL STATUS	Group	
	Group A	**Group B**
MARRIED	40 (80%)	9(18%)
SINGLE	10(20%)	41(82%)
Total	**50**	**50**

Figure 7: Distribution of Participants (patients with SUD and control group) in Terms of marital status (n=100)

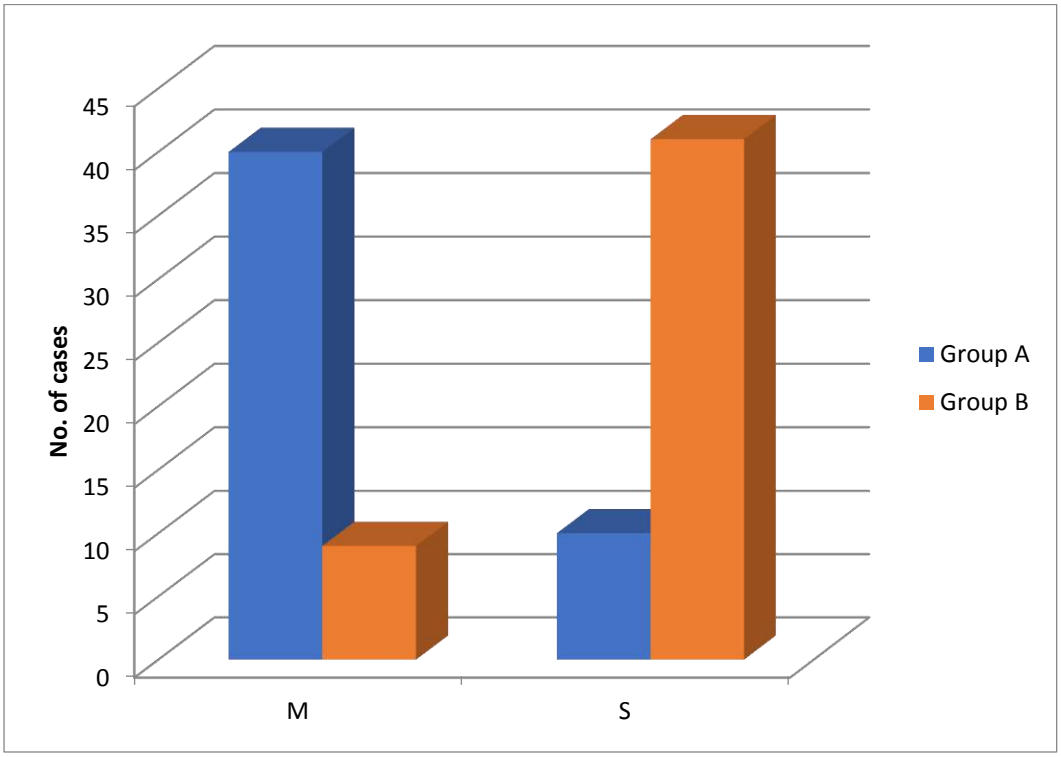


Table 7: Comparison between the parental relationship between patients with SUD and participants without SUD (n=100)

RELATION	Group A		Group B		t	p-value
	Mean	SD	Mean	SD		
PACQ-M	22.98	6.53	24.14	3.96	-1.074	0.286
PACQ-F	25.58	5.99	26.72	3.36	-1.173	0.244

Figure 8: Comparison between the parental relationship between patients with SUD and participants without SUD (n=100)

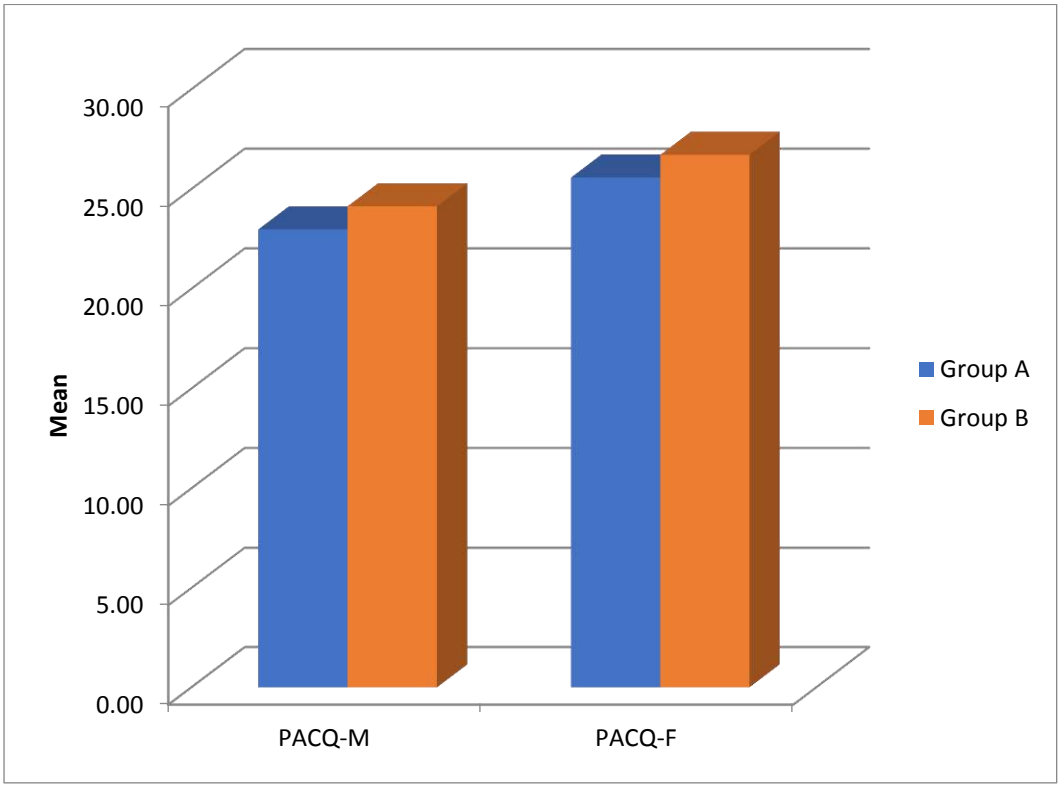


Table 8: Comparison between the parental relationship between patients with SUD and participants without SUD (n=100)

PARENTAL RELATION VARIABLES	Group A		Group B		t	p-value
	Mean	SD	Mean	SD		
PACQ-M (REG)	11.16	3.79	13.74	2.23	-4.151	**0.000**
PACQ-M(RES)	11.88	5.03	10.48	2.67	1.738	0.085
PACQ-F(REG)	8.32	3.25	10.44	1.40	-4.238	**0.000**
PACQ-F(RES)	6.96	3.08	9.80	1.82	-5.619	**0.000**
PACQ-F (CON)	9.94	3.01	6.40	1.78	7.148	**0.000**

Figure 9: Comparison between the parental relationship between patients with SUD and participants without SUD (n=100)

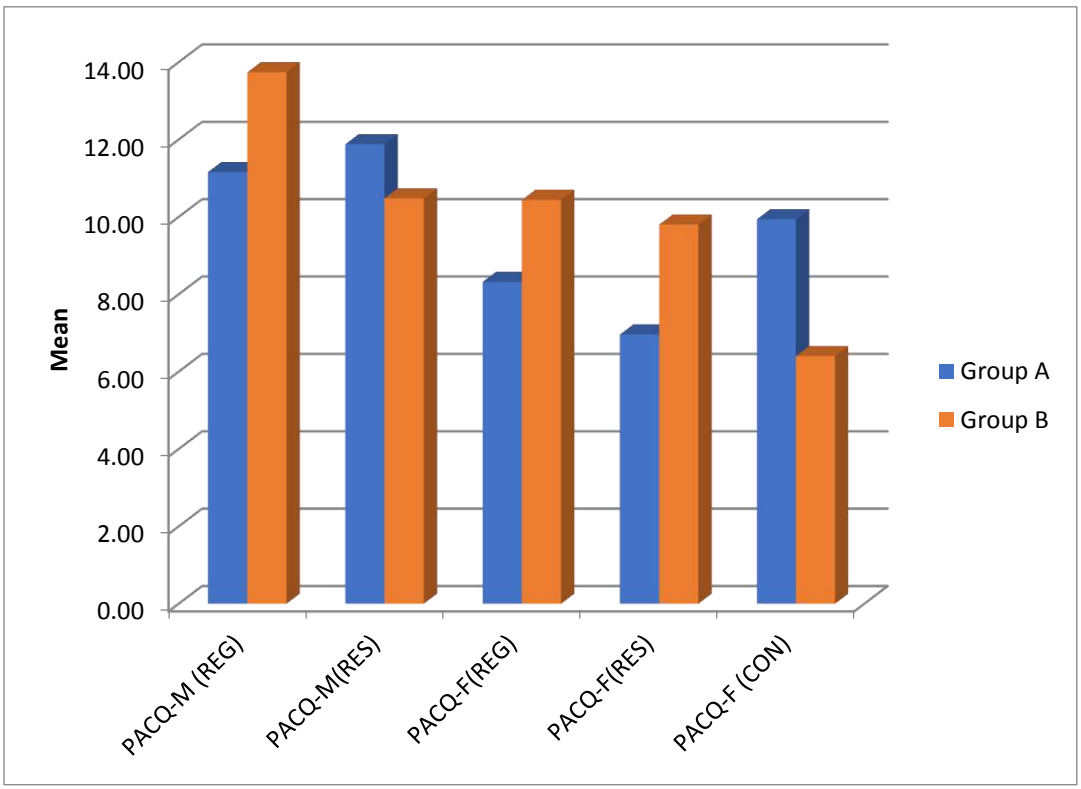


Table 9: Comparison between the attributional bias (externalizing and personalizing bias, EB and PB) between patients with SUD and participants without SUD (n=100)

Externalizing/ personalizing bias	Group A		Group B		t	p-value
	Mean	SD	Mean	SD		
EB	0.54	4.66	1.66	3.50	-1.360	0.177
PB	0.59	0.47	0.54	0.28	0.680	0.498

Figure 10: Comparison between the attributional bias (externalizing and personalizing bias, EB and PB) between patients with SUD and participants without SUD (n=100)

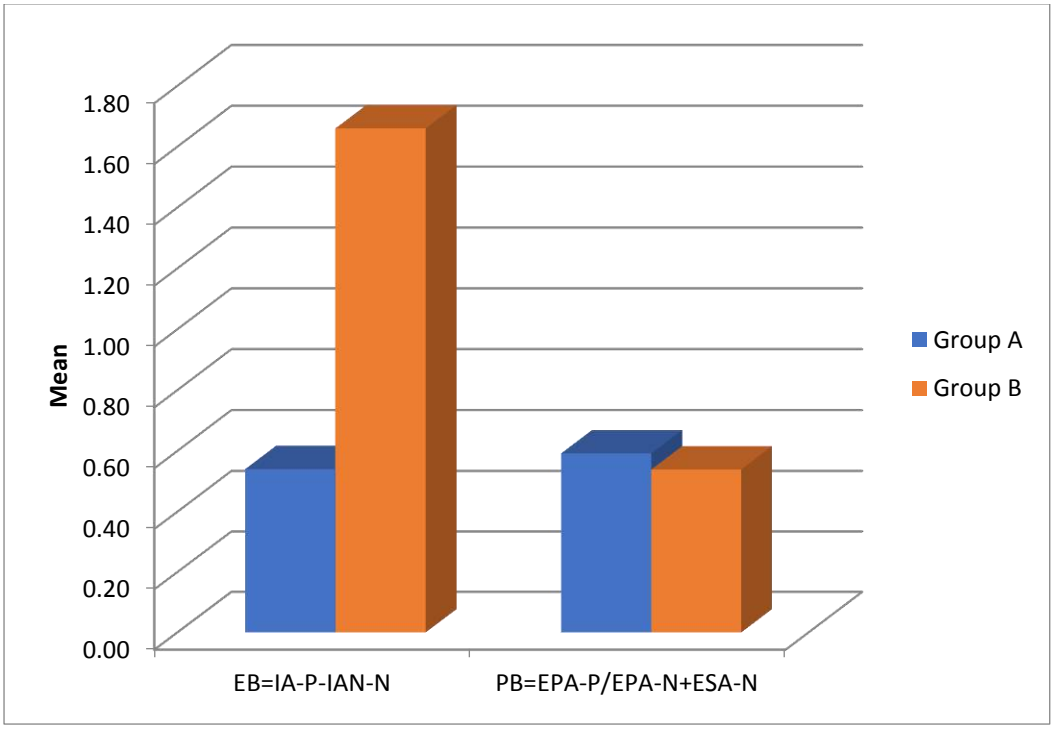


Table 10: Comparison between the attributional bias (internal bias for positive and negative events, IA-P and IA-N) between patients with SUD and participants without SUD (n=100)

INTERNAL ATTRIBUTION	Group A		Group B		t	p-value
	Mean	SD	Mean	SD		
IA-P	7.42	2.87	7.92	2.03	-1.005	0.317
IA-N	6.96	3.08	6.38	2.07	1.106	0.271

Figure 11: Comparison between the attributional bias (internal bias for positive and negative events, IA-P and IA-N) between patients with SUD and participants without SUD (n=100)

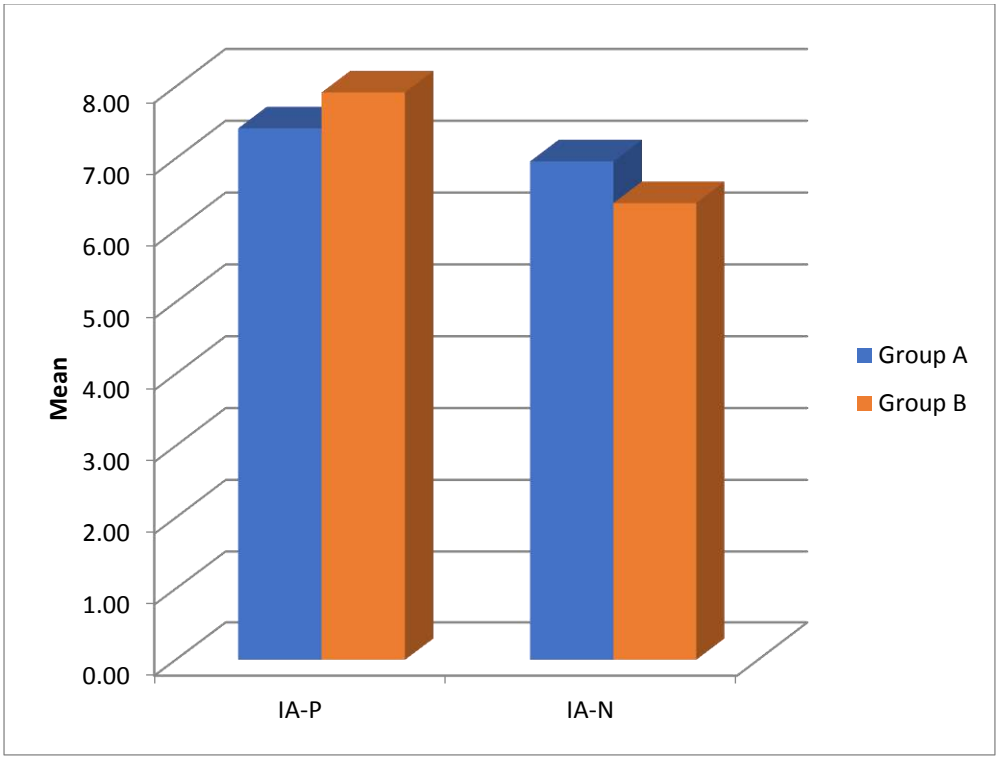


Table 11: Comparison between the attributional bias (external personal bias for positive and negative events, EPA-P and EPA-N) between patients with SUD and participants without SUD (n=100)

Externalizing Personal Bias	Group A		Group B		t	p-value
	Mean	SD	Mean	SD		
EPA-P	4.46	2.11	4.86	1.75	-1.031	0.305
EPA-N	4.64	2.51	5.56	1.51	-2.217	**0.029**

Figure 12: Comparison between the attributional bias (external personal bias for positive and negative events, EPA-P and EPA-N) between patients with SUD and participants without SUD (n=100)

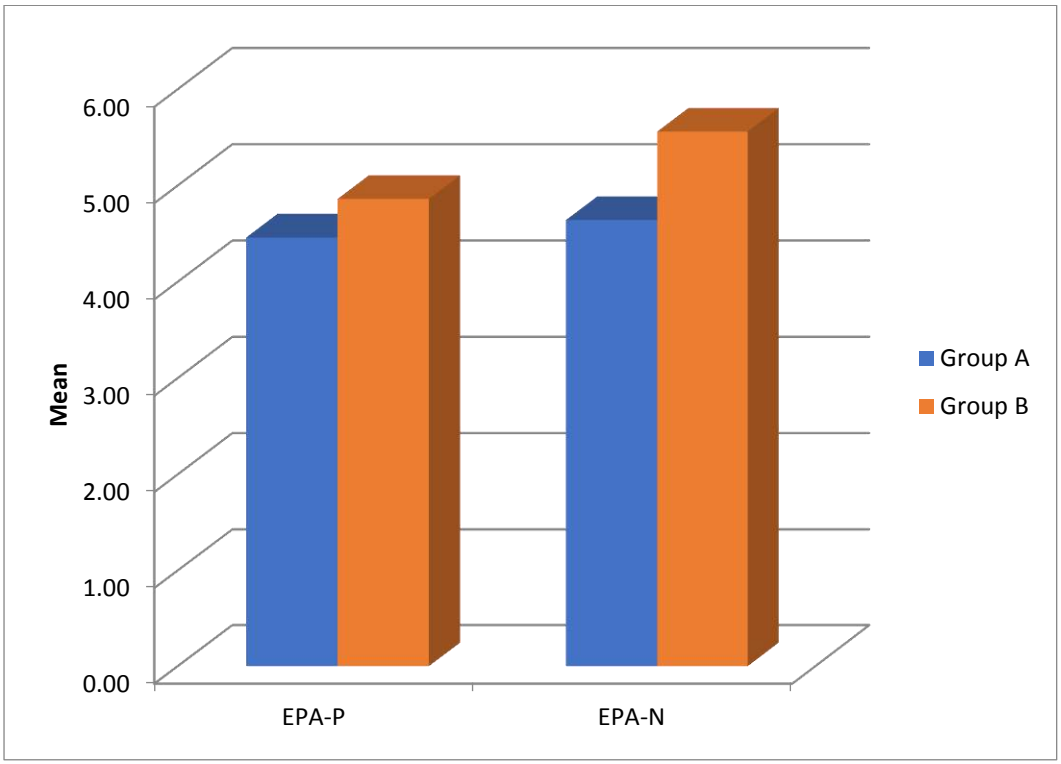


Table 12: Comparison between the attributional bias (external situational bias for positive and negative events, ESA-P and ESA-N) between patients with SUD and participants without SUD (n=100)

External Situational Bias	Group A		Group B		t	p-value
	Mean	SD	Mean	SD		
ESA-P	4.06	1.83	3.24	1.35	2.547	**0.012**
ESA-N	4.42	1.99	4.24	1.64	0.494	0.622

Figure 13: Comparison between the attributional bias (external situational bias for positive and negative events, ESA-P and ESA-N) between patients with SUD and participants without SUD (n=100)

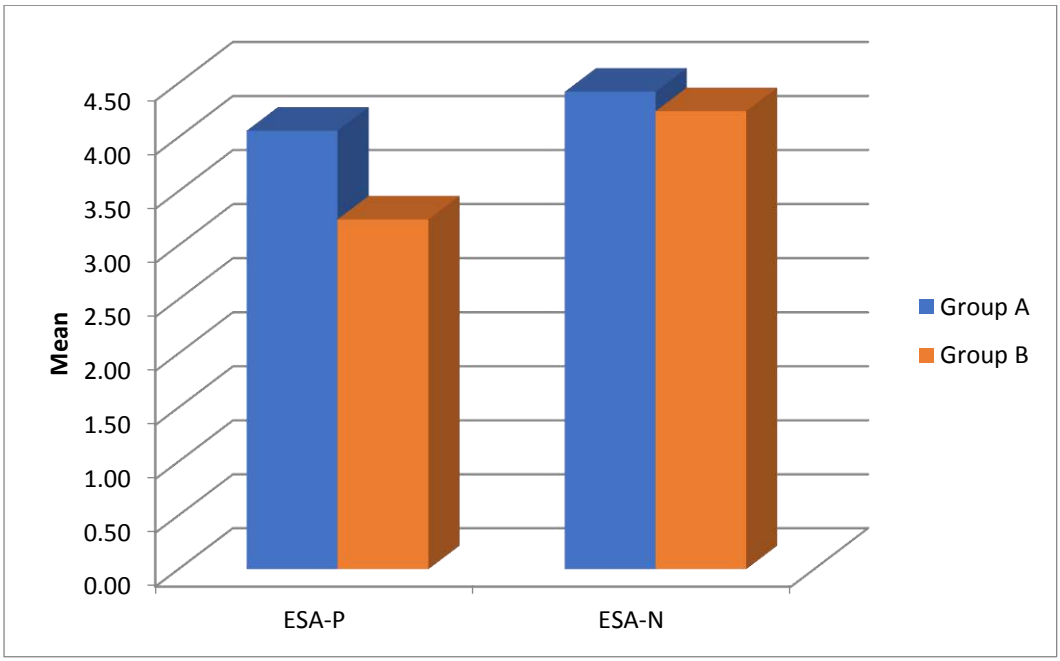


Table 13: Comparison between the types of conflicts (SACKS total scores) between patients with SUD and participants without SUD (n=100)

TYPES OF CONFLICT	GROUP A		GROUP B			
	MEAN	SD	MEAN	SD	t	p-value
SACKS TOTAL	29.12	7.27	0.44	0.97	27.631	**0.000**

Figure 14: Comparison between the types of conflicts (SACKS total scores) between patients with SUD and participants without SUD (n=100)

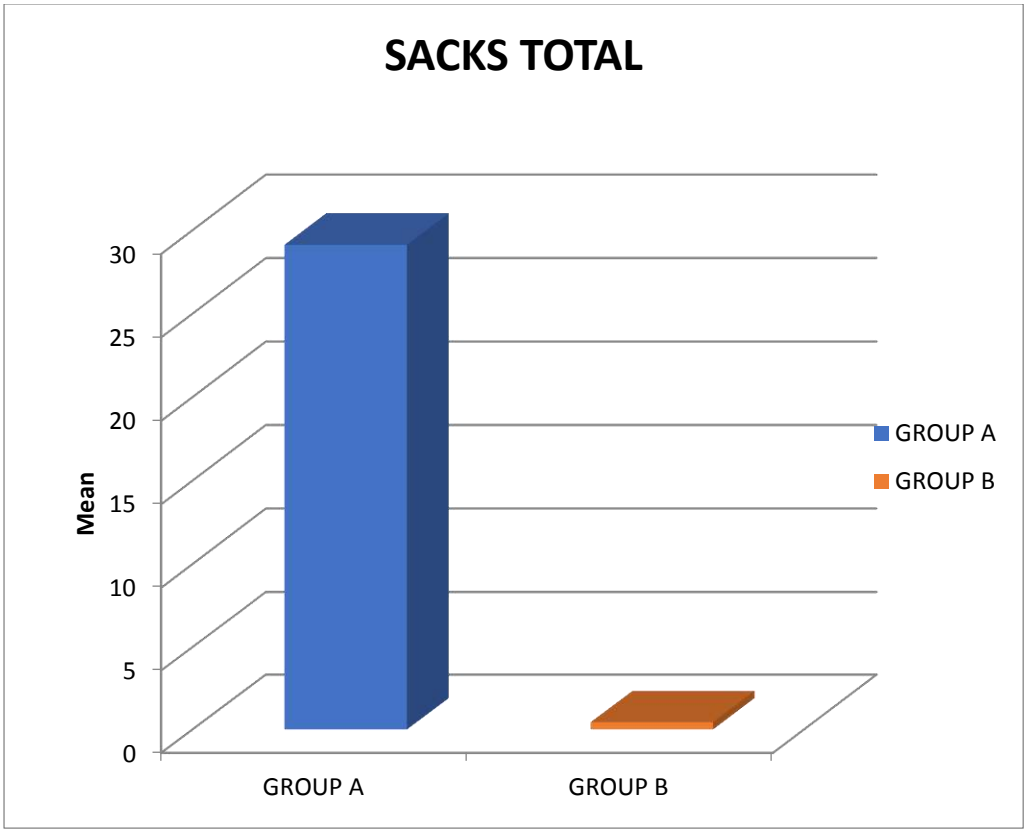


Table 14: Comparison between the types of conflicts (SACKS family area scores) between patients with SUD and participants without SUD (n=100)

TYPES OF CONFLICTS	GROUP A		GROUP B			
	MEAN	**SD**	**MEAN**	**SD**	**t**	**p-value**
SACKS- FA	5.84	3.94	0.14	0.53	10.136	**0.000**
MOTHER	2.72	1.61	0.00	0.00	5.880	**0.000**
FATHER	11.88	5.03	0.06	0.24	11.092	**0.000**
FAMILY UNIT	25.58	5.99	24.14	3.96	6.696	**0.000**

Figure 15: Comparison between the types of conflicts (SACKS family area scores) between patients with SUD and participants without SUD (n=100)

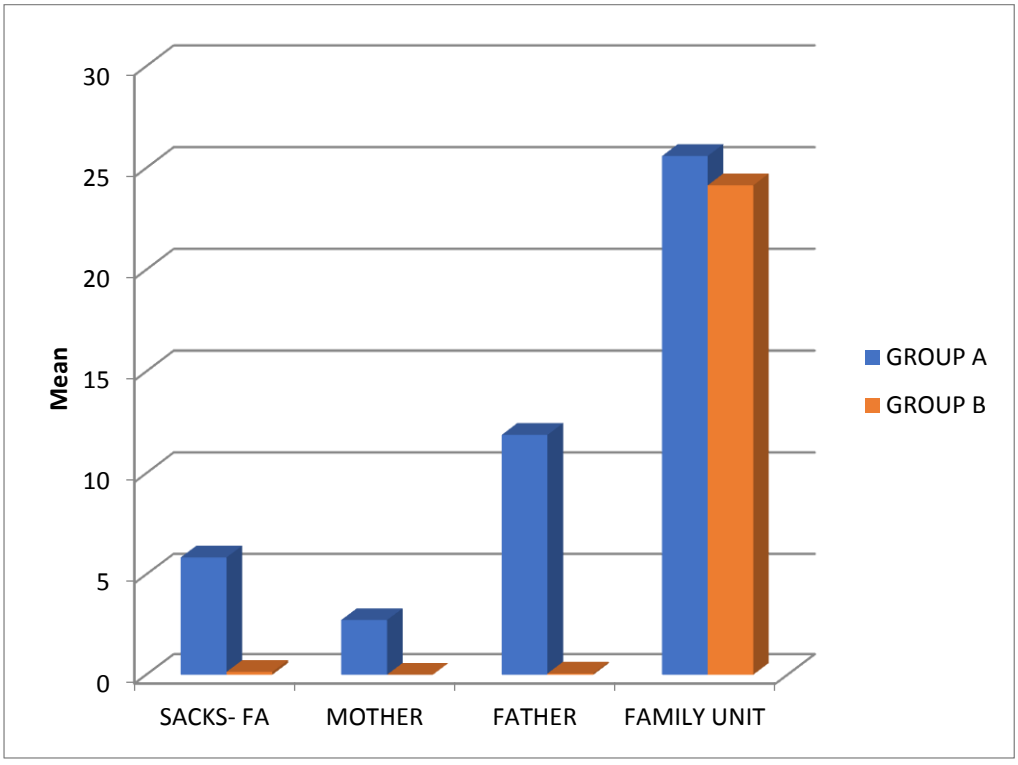


Table 15: Comparison between the types of conflicts (SACKS sex area scores) between patients with SUD and participants without SUD (n=100)

TYPES OF CONFLICTS	GROUP A		GROUP B			
	MEAN	SD	MEAN	SD	t	p-value
SACKS- SA	1.86	1.47	0.00	0.00	8.941	**0.000**
FEMALE	1.26	1.12	0.00	0.00	7.945	**0.000**
HETEROSEXUAL	0.60	0.78	0.00	0.00	5.422	**0.000**

Figure 16: Comparison between the types of conflicts (SACKS sex area scores) between patients with SUD and participants without SUD (n=100)

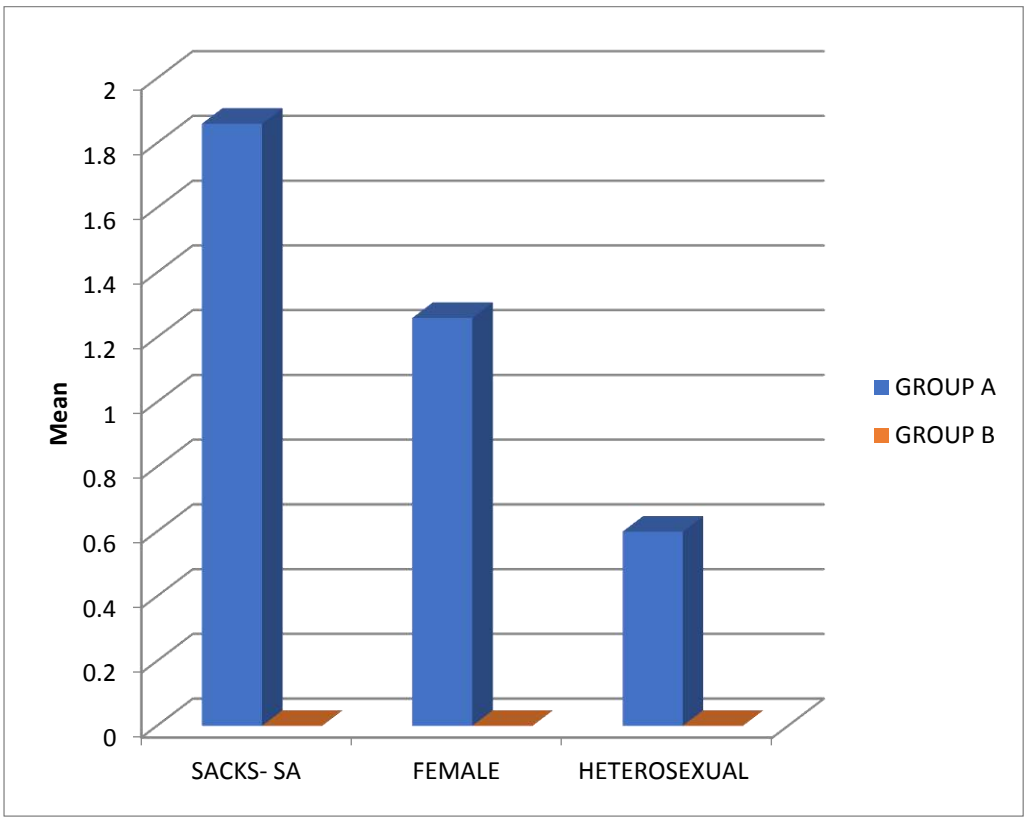


Table 16: Comparison between the types of conflicts (SACKS interpersonal area scores) between patients with SUD and participants without SUD (n=100)

TYPES OF CONFLICTS	GROUP A		GROUP B			
	MEAN	**SD**	**MEAN**	**SD**	**t**	**p-value**
SACKS- IR	9.38	3.43	0.38	0.92	17.897	**0.000**
FRIENDS	2.32	1.27	0.10	0.36	11.892	**0.000**
SUPERVISED	1.40	1.36	0.04	0.28	6.946	**0.000**
COLLEAGUES	1.54	1.45	0.06	0.31	7.074	**0.000**
SUPERIORS	1.12	1.22	0.10	0.36	5.652	**0.000**
FEAR	2.90	1.89	0.08	0.27	10.475	**0.000**

Figure 17: Comparison between the types of conflicts (SACKS interpersonal area scores) between patients with SUD and participants without SUD (n=100)

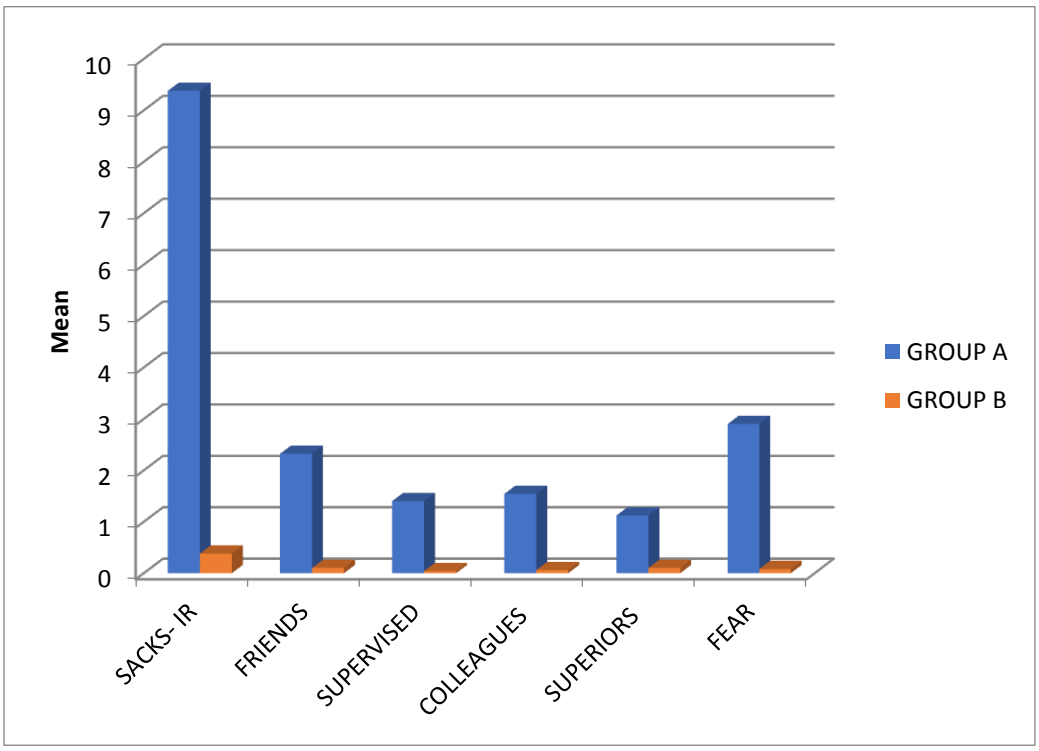


Table 17: Comparison between the types of conflicts (SACKS self-concept area scores) between patients with SUD and participants without SUD (n=100)

TYPES OF CONFLICTS	GROUP A		GROUP B			
	MEAN	SD	MEAN	SD	t	p-value
SACKS- SC	12.36	3.38	0.12	0.39	25.448	**0.000**
GUILT	3.56	1.75	0.00	0.00	14.372	**0.000**
ABILITY	3.00	1.54	0.04	0.20	13.492	**0.000**
PAST	1.18	1.17	0.02	0.14	6.944	**0.000**
FUTURE	2.38	1.84	0.06	0.24	8.844	**0.000**
GOAL	2.30	1.52	0.00	0.00	10.733	**0.000**

Figure 18: Comparison between the types of conflicts (SACKS self-concept area scores) between patients with SUD and participants without SUD (n=100)

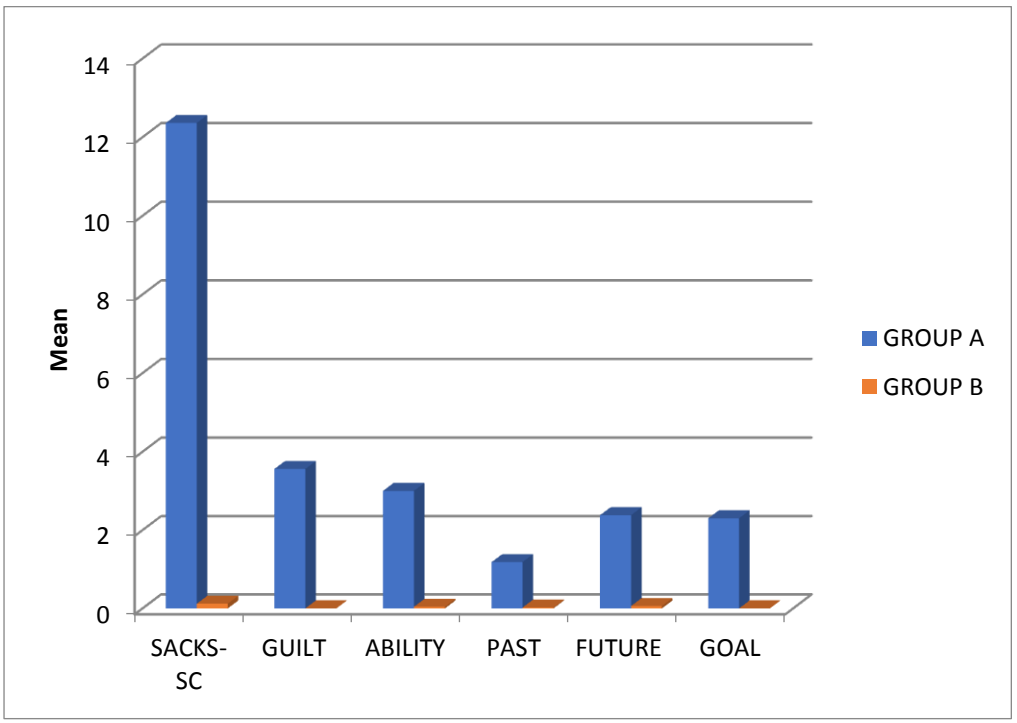


Table 18: Comparison of motivational needs between patients with SUD and participants without SUD (n=100)

MOTIVATIONAL NEED	Group A		Group B		t	p-value
	Mean	SD	Mean	SD		
MQ-ACH	3.14	1.66	6.56	1.23	-11.656	**0.000**
MQ-AFF	2.31	1.47	2.78	1.25	-1.726	0.088
MQ-POW	5.53	1.68	1.66	0.82	14.569	**0.000**

Figure 19: Comparison of motivational needs between patients with SUD and participants without SUD (n=100)

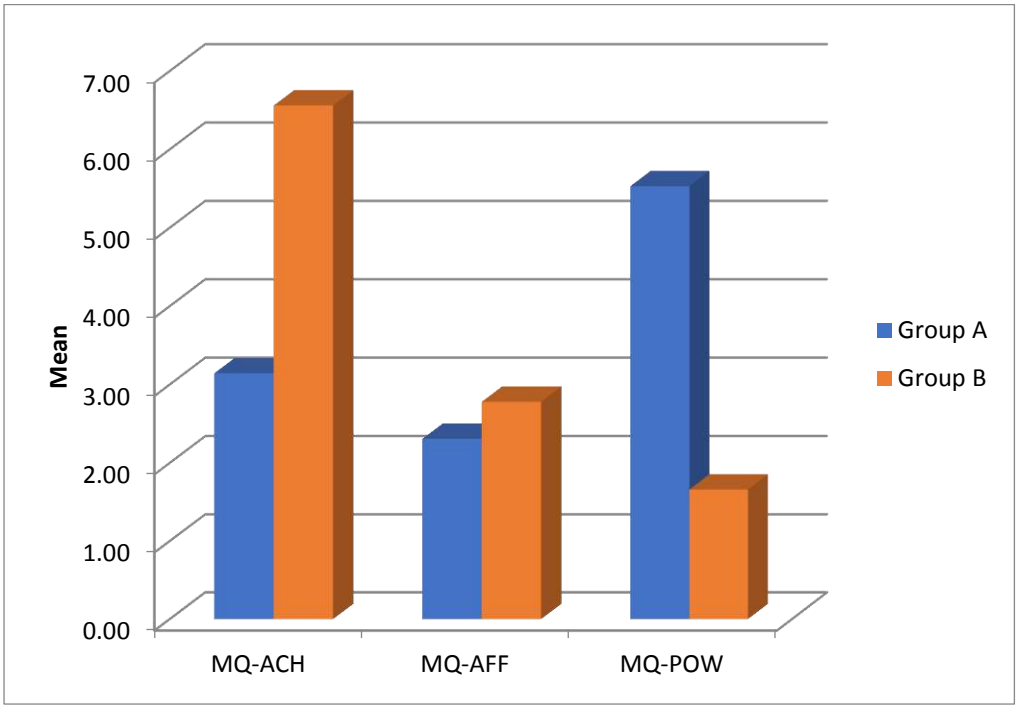


Table 19: Comparison between the parental relationship (with mother) between patients with opioid use and patients with alcohol use (n=50)

PARENTAL RELATIONSHIP	GROUP A (OPIOID)		GROUP B (ALCOHOL)			
	MEAN	SD	MEAN	SD	t	p-value
PCAQM	24.04	7.39	21.92	5.48	1.152	0.255
PCAQM(REG)	10.68	3.96	11.64	3.63	-0.894	0.376
PCAQM(RES)	13.48	4.93	10.28	4.70	2.351	**0.023**

Figure 20: Comparison between the parental relationship (with mother) between patients with opioid use and patients with alcohol use (n=50)

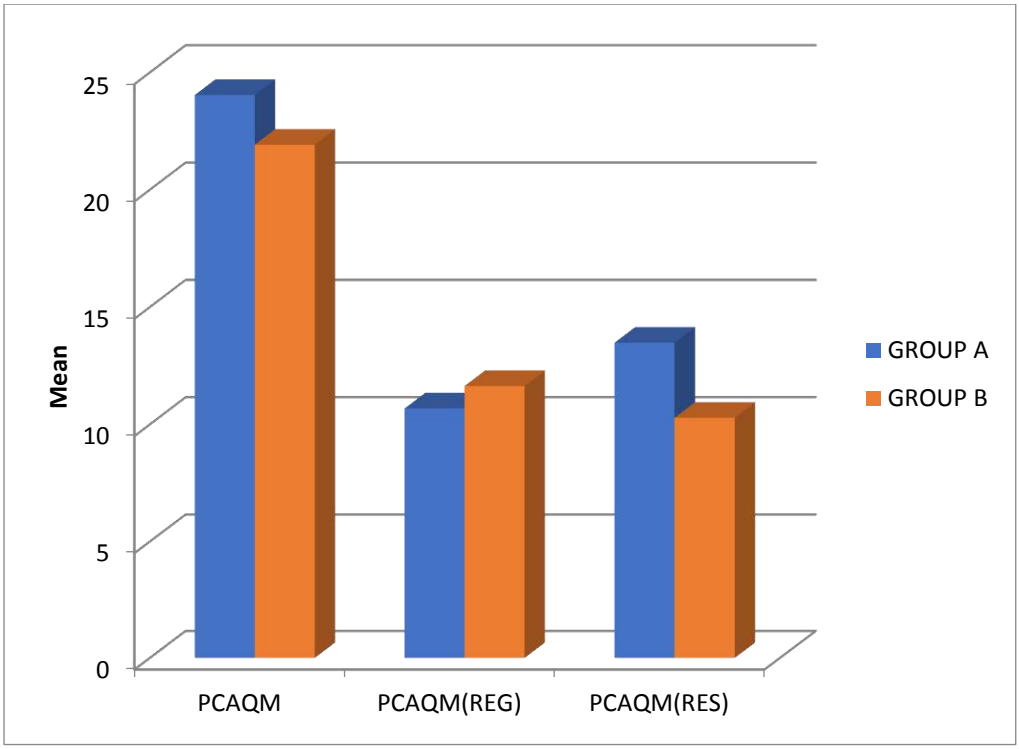


Table 20: Comparison between the types of conflicts (SACKS interpersonal area scores) between patients with opioid use and patients with alcohol use (n=50)

TYPES OF CONFLICTS	GROUP A (OPIOIDS)		GROUP B (ALCOHOL)			
	MEAN	SD	MEAN	SD	t	p-value
SACKS- IR	9.60	3.98	9.16	2.85	0.449	0.655
FRIENDS	2.76	1.20	1.88	1.20	2.591	**0.013**
SUPERVISED	1.44	1.42	1.36	1.32	0.207	0.837
COLLEAGUES	0.72	0.98	2.36	1.38	-4.843	**0.000**
SUPERIORS	1.20	1.22	1.04	1.24	0.459	0.648
FEAR	3.32	2.17	2.48	1.48	1.599	0.116

Figure 21: Comparison between the types of conflicts (SACKS interpersonal area scores) between patients with opioid use and patients with alcohol use (n=50)

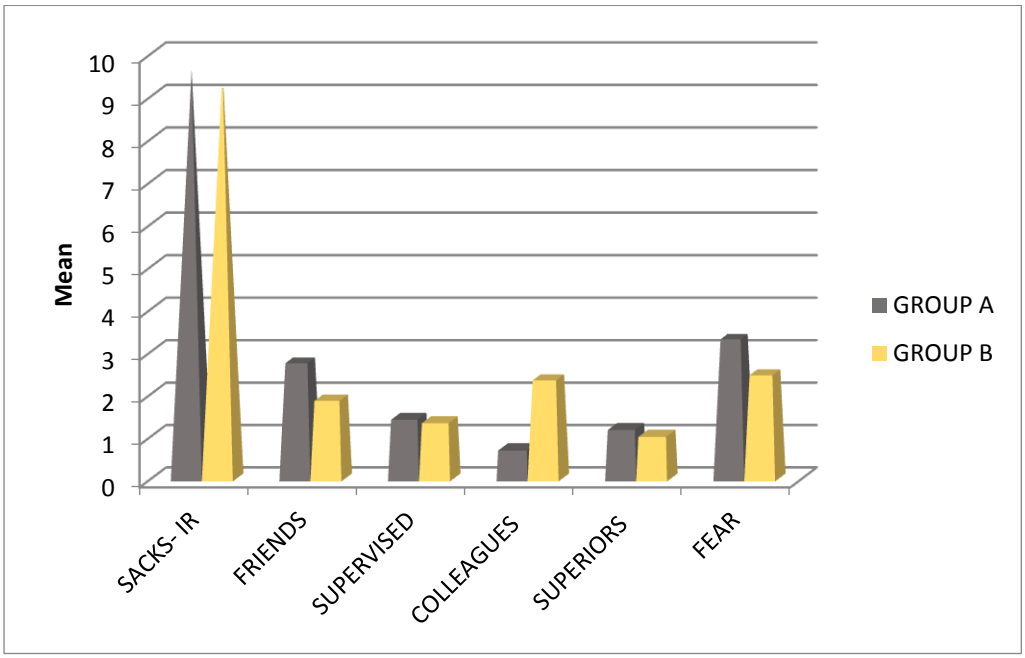


Table 21: Comparison between the types of conflicts (SACKS self-concept area scores) between patients with opioid use and patients with alcohol use (n=50)

TYPES OF CONFLICTS	GROUP A (OPIOIDS)		GROUP B (ALCOHOL)			
	MEAN	**SD**	**MEAN**	**SD**	**t**	**p-value**
SACKS-SC	12.48	3.81	12.24	2.96	0.249	0.805
GUILT	4.28	1.70	2.84	1.52	3.162	**0.003**
ABILITY	2.72	1.72	3.28	1.31	-1.296	0.201
PAST	1.20	1.26	1.16	1.11	0.119	0.905
FUTURE	2.00	1.87	2.76	1.76	-1.478	0.146
GOAL	2.40	1.85	2.20	1.12	0.463	0.646

Figure 22: Comparison between the types of conflicts (SACKS self-concept area scores) between patients with opioid use and patients with alcohol use (n=50)

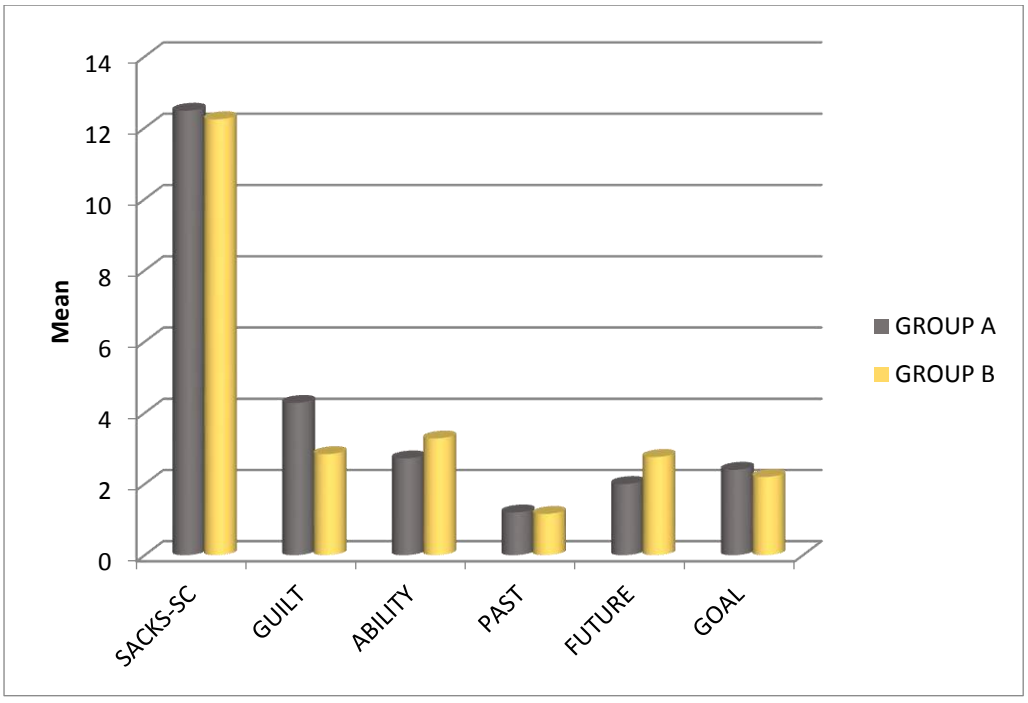
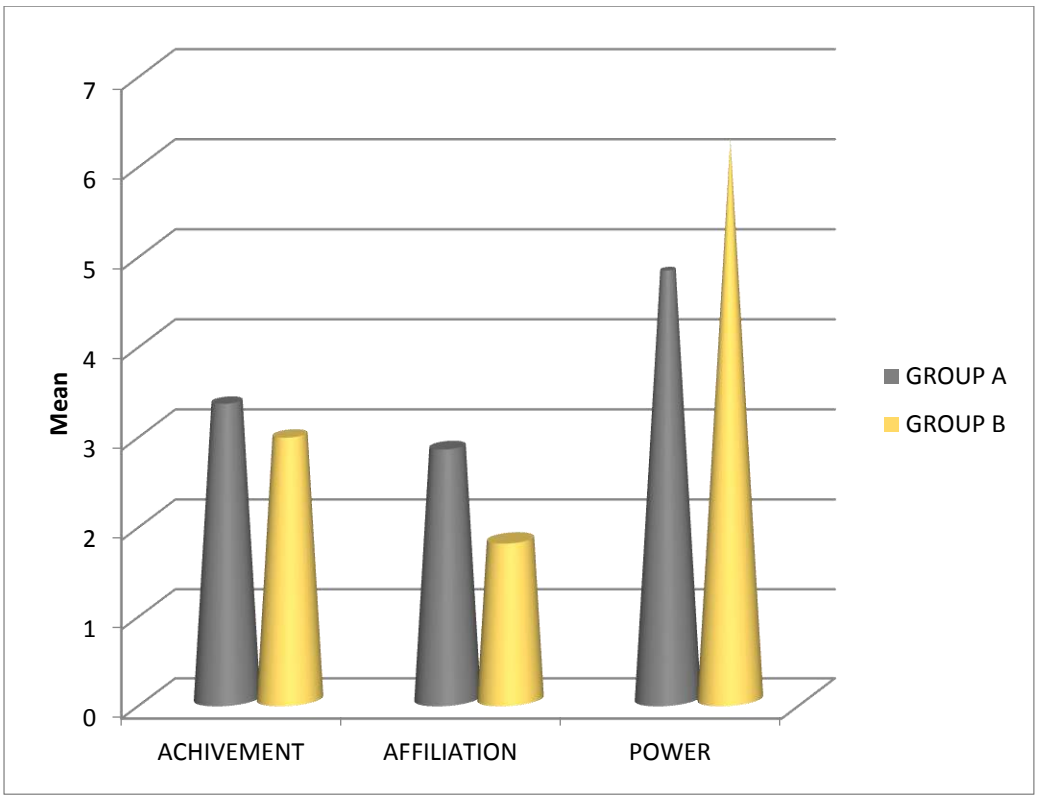


Table 22: Comparison of motivational needs between patients with opioid use and patients with alcohol use (n=50)

MOTIVATIONAL NEEDS	GROUP A (OPIOIDS)		GROUP B (ALCOHOL)			
	MEAN	SD	MEAN	SD	t	p-value
ACHIEVEMENT	3.33	1.76	2.96	1.57	0.785	0.437
AFFILIATION	2.83	1.58	1.80	1.19	2.594	**0.013**
POWER	4.79	1.69	6.24	1.36	-3.305	**0.002**

Figure 23: Comparison of motivational needs between patients with opioid use and patients with alcohol use (n=50)



RESULTS

Study was conducted on 50 SUD patients (25 having alcohol use disorder and 25 having opioid use disorder), admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College and Hospital and 50 healthy individuals as control group from 18 to 35 years of age from general population.

Socio Demographic Performa was filled containing the basic information of the subject and they were evaluated for parental relationship using the parent adult-child relationship questionnaire (PACQ), attributional bias using internal, personal and situational attribute questionnaire (IPSAQ), motivational needs using motivational questionnaire and types of conflicts by administering sacks sentence completion test (SSCT).

Table 1 and figure 2 shows that 6% participants (patients having substance use disorder) were of the age group 18-24 years, 36% in the age group 25-29 years and 58% in the age group 30-35 years of age. In the control group, 22% participants were of the age group 18-24 years, 54% in the age group 25-29 years and 24% in the age group 30-35 years of age.

Table 2 and figure 3 shows that mean age of the participants (patients having substance use disorder) was 29.34, with SD of 4.80 and range was from 18-35 years. The mean age of the participants (control group) was 27.28, with SD of 3.55 and range was from 18-35 years. There was significant difference in the mean age of the two groups with a p value of 0.016 and a t value of 2.442.

Table 3 and figure 4 shows the distribution of patients with SUD in terms of drug use where 25 patients used alcohol and 25 used opioids.

Table 4 and Figure 5 shows that 24% participants (patients with SUD) were rural and 76% were urban. In the control group,0% participants were rural and 100% were urban.

Table 5 and Figure 6 shows that 46% participants (patients with SUD) belonged to joint family and 54% belonged to nuclear family. In the control group12% participants belonged to joint family and 88% belonged to nuclear family.

Table 6 and Figure 7 shows that 80% participants (patients with SUD) were single and 20% were married. In the control group, 82% participants were single and 18% were married.

Table 7 and Figure 8 show the comparison between the scores of parent child adult relationship score for mother form and parent adult relationship score for father form for the both the groups. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. PACQM total mean score for group A was 22.98 with SD of 6.53, for group B, the mean score was 24.14 with SD 3.96.There was no significant difference between the groups in terms of total score on mother domain (PCAQM) (t= -1.074, p-value = 0.286). PACQF total mean score for group A was 25.58 with SD of 5.99, for group B, the mean score was 26.72 with SD 3.36.There was no significant difference between the groups in terms of total score on father domain (PCAQF) (t= -1.173, p-value = 0.244).

Table 8 and Figure 9 show the comparison between the scores of parent child adult relationship score for mother form and parent adult relationship score for father form for the both the groups for different factors namely: regard, responsibility and control. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. PACQM (regard scale) mean score for group A was 11.16 with SD of 3.79, for group B, the mean score was 13.74 with SD 2.23.There was significant difference between the groups in terms of score on regard domain of mother form (PCAQM-REG) (t= -4.151, p-value = 0.000). PACQM (responsibility scale) mean score for group A was 11.88 with SD of 5.03, for group B, the mean score was 10.48 with SD 2.67.There was no significant difference

between the groups in terms of score on responsibility domain of mother form (PCAQM- RES) (t= 1.738, p-value = 0.085).

PACQF (regard scale) mean score for group A was 8.32 with SD of 3.25, for group B, the mean score was 10.44 with SD 1.40.There was significant difference between the groups in terms of score on regard domain of mother form (PCAQF- REG) (t= -4.238, p-value = 0.000). There is higher mean score for regard domain of Group B than Group A. PACQF (responsibility scale) mean score for group A was 6.96 with SD of 3.08, for group B, the mean score was 9.80 with SD 1.82.There was significant difference between the groups in terms of score on responsibility domain of father form (PCAQF- RES) (t= -5.619, p-value = 0.000). There is higher mean score for responsibility domain of Group B than Group A. PACQF (control scale) mean score for group A was 9.94 with SD of 3.01, for group B, the mean score was 6.40 with SD 1.78. There was significant difference between the groups in terms of score on responsibility domain of father form (PCAQF- CON) (t= 7.148, p-value = 0.000). There is higher mean score for control domain of Group A than Group B.

Table 9 and Figure 10 show the comparison between the scores of attributional bias- externalizing and personalizing bias. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. Externalizing bias (EB) total mean score for group A (patients with SUD) was 0.54 with SD of 4.66, for group B (control group), the mean score was 1.66 with SD 3.50.There was no significant difference between the groups in terms of total score on EB domain (t= -1.360, p-value = 0.177). Personalizing bias (PB) mean score for group A was 0.59 with SD of 0.47, for group B, the mean score was 0.54 with SD 0.28. There was no significant difference between the groups in terms of score on PB domain (t= 0.680, p-value = 0.498). Mean scores were higher for PB in Group A as compared to Group B. Mean scores for EB was higher for Group B as compared to Group A.

Table 10 and Figure 11 show the comparison between the scores of attributional bias- internal bias for positive and negative events. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. Internal bias for positive events (IA-P) total mean score for group A (patients with SUD) was 7.42 with SD of 2.87, for group B (control group), the mean score was 7.92 with SD 2.03.There was no significant difference between the groups in terms of total score on IA-P domain (t= -1.005, p-value = 0.317). Internal bias for negative events (IA-N) mean score for group A was 6.96 with SD of 3.08, for group B, the mean score was 6.38 with SD 2.07.There was no significant difference between the groups in terms of score on PB domain (t= 1.106, p-value = 0.271). Mean scores were higher for IA-P in Group B as compared to Group A. Mean scores for IA-N were higher for Group A as compared to Group B.

Table 11 and Figure 12 show the comparison between the scores of attributional bias- external personal bias for positive and negative events. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. External personal bias for positive events (EPA-P) total mean score for group A (patients with SUD) was 4.46 with SD of 2.11, for group B (control group), the mean score was 4.86 with SD 1.75.There was no significant difference between the groups in terms of total score on EPA-P domain (t= -1.031, p-value = 0.305). External personal bias for negative events (EPA-N) mean score for group A was 4.64 with SD of 2.51, for group B, the mean score was 5.56 with SD 1.51.There was significant difference between the groups in terms of score on PB domain (t= -2.217, p-value = 0.029). Mean scores were higher for EPA-P in Group B as compared to Group A. Mean scores for EPA-N were higher for Group B as compared to Group A.

Table 12 and Figure 13 show the comparison between the scores of attributional bias- external situational bias for positive and negative events. Since both the groups were normally distributed, thus

parametric tests (t-test) was used to make the comparisons. External situational bias for positive events (ESA-P) total mean score for group A (patients with SUD) was 4.06 with SD of 1.83, for group B (control group), the mean score was 4.42 with SD 1.64.There was significant difference between the groups in terms of total score on ESA-P domain (t= 2.574, p-value = 0.012). External situational bias for negative events (ESA-N) mean score for group A was 4.42 with SD of 1.99, for group B, the mean score was 5.56 with SD 1.51.There was no significant difference between the groups in terms of score on PB domain (t= 0.494, p-value = 0.622). Mean scores were higher for ESA-P in Group A as compared to Group B. Mean scores for ESA-N was higher for Group A as compared to Group B.

Table 13 and Figure 14 show the comparison between the scores of Sack's sentence completion test for types of conflicts. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. SACKS total mean score for group A (patients with SUD) was 29.12 with SD of 7.27, for group B (control group), the mean score was 0.44 with SD 0.97. There was significant difference between the groups in terms of total score SACKS (t= 27.631, p-value = 0.000). Mean scores were higher for SACKS total score in Group A as compared to Group B.

Table 14 and Figure 15 show the comparison between the scores of Sack's sentence completion test for Family area. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. SACKS-FA total mean score for group A (patients with SUD) was 5.84 with SD of 3.94, for group B (control group), the mean score was 0.14 with SD 0.53. There was significant difference between the groups in terms of total score SACKS-FA (t= 10.136, p-value = 0.000). Mean scores were higher for SACKS-FA total score in Group A as compared to Group B. SACKS- FA mother domain mean score for group A (patients with SUD) was 2.72 with SD of 1.61, for group B (control group), the mean score was 0.00 with SD 0.00.

There was significant difference between the groups in terms of mean score SACKS-FA mother domain (t= 5.880, p-value = 0.000). Mean scores were higher for SACKS-FA mother domain total score in Group A as compared to Group B. SACKS-FA father domain mean score for group A (patients with SUD) was 11.88 with SD of 5.03, for group B (control group), the mean score was 0.06 with SD 0.06. There was significant difference between the groups in terms of mean score SACKS-FA father domain (t= 11.092, p-value = 0.000). Mean scores were higher for SACKS-FA father domain total score in Group A as compared to Group B. SACKS-FA family unit domain total mean score for group A (patients with SUD) was 25.58 with SD of 5.99, for group B (control group), the mean score was 24.14 with SD 3.96. There was significant difference between the groups in terms of total score SACKS-FA (t= 6.696, p-value = 0.000). Mean scores were higher for SACKS-FA family unit domain total score in Group A as compared to Group B.

Table 15 and Figure 16 show the comparison between the scores of Sack's sentence completion test for Sex area. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. SACKS-SA total mean score for group A (patients with SUD) was 1.86 with SD of 1.47, for group B (control group), the mean score was 0.00 with SD 0.000. There was significant difference between the groups in terms of total score SACKS-SA (t= 8.941, p-value = 0.000). Mean scores were higher for SACKS-SA total score in Group A as compared to Group B. SACKS-SA attitude towards female domain mean score for group A (patients with SUD) was 1.26 with SD of 1.12, for group B (control group), the mean score was 0.00 with SD 0.00. There was significant difference between the groups in terms of mean score SACKS-SA female domain (t= 7.945, p-value = 0.000). Mean scores were higher for SACKS-SA female domain total score in Group A as compared to Group B. SACKS-SA heterosexual domain mean score for group A (patients with SUD) was 0.60 with SD o 0.78, for group B (control group), the mean score was

0.00 with SD 0.00. There was significant difference between the groups in terms of mean score SACKS-SA heterosexual domain (t= 5.422, p-value = 0.000). Mean scores were higher for SACKS-SA heterosexual domain total score in Group A as compared to Group B.

Table 16 and Figure 17 show the comparison between the scores of Sack's sentence completion test for Interpersonal area. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. SACKS-IR total mean score for group A (patients with SUD) was 9.38 with SD of 3.43, for group B (control group), the mean score was 0.38 with SD 0.92. There was significant difference between the groups in terms of total score SACKS-IR (t= 17.897, p-value = 0.000). Mean scores were higher for SACKS- IR total score in Group A as compared to Group B, which indicates that there is higher interpersonal conflict in patients with substance use disorder, as compared to control group. SACKS- IR relationship with friends domain mean score for group A (patients with SUD) was 2.32 with SD of 1.27, for group B (control group), the mean score was 0.10 with SD 0.36. There was significant difference between the groups in terms of mean score SACKS-IR friends domain (t= 11.892, p-value = 0.000). Mean scores were higher for SACKS-IR friends domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in areas of relation with friends in patients with substance use disorder as compared to control group. SACKS-IR relationship with supervised domain mean score for group A (patients with SUD) was 1.40 with SD of 1.36, for group B (control group), the mean score was 0.04 with SD 0.28. There was significant difference between the groups in terms of mean score SACKS-IR supervised domain (t= 6.946, p-value = 0.000). Mean scores were higher for SACKS-IR supervised domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in areas of relation with supervised in patients with substance use disorder as compared to control group. SACKS-IR relationship with supervised domain mean score for group A (patients with SUD) was 1.40 with SD of 1.36, for group B (control group), the mean score

was 0.04 with SD 0.28. There was significant difference between the groups in terms of mean score SACKS-IR supervised domain (t= 6.946, p-value = 0.000). Mean scores were higher for SACKS-IR supervised domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in areas of relation with supervised in patients with substance use disorder as compared to control group.

SACKS-IR relationship with colleagues domain mean score for group A (patients with SUD) was 1.54 with SD of 1.45, for group B (control group), the mean score was 0.06 with SD 0.31. There was significant difference between the groups in terms of mean score SACKS-IR colleagues domain (t= 7.074, p-value = 0.000). Mean scores were higher for SACKS-IR colleagues domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in areas of relation with colleagues in patients with substance use disorder as compared to control group.

SACKS-IR relationship with superiors domain mean score for group A (patients with SUD) was 1.12 with SD of 1.22, for group B (control group), the mean score was 0.10 with SD 0.36. There was significant difference between the groups in terms of mean score SACKS-IR supervised domain (t= 5.652, p-value = 0.000). Mean scores were higher for SACKS-IR superiors domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in areas of relation with superiors in patients with substance use disorder as compared to control group. SACKS-IR fear domain mean score for group A (patients with SUD) was 2.90 with SD of 1.89, for group B (control group), the mean score was 0.08 with SD 0.27. There was significant difference between the groups in terms of mean score SACKS-IR fear domain (t= 10.457, p-value = 0.000). Mean scores were higher for SACKS-IR fear domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in area of

fear in patients with substance use disorder as compared to control group.

Table 17 and Figure 18 show the comparison between the scores of Sack's sentence completion test for Self-concept area. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. SACKS-SC total mean score for group A (patients with SUD) was 12.36 with SD of 3.38, for group B (control group), the mean score was 0.12 with SD 0.39. There was significant difference between the groups in terms of total score SACKS-SC (t= 25.448, p-value = 0.000). Mean scores were higher for SACKS- SC total score in Group A as compared to Group B, which indicates that there are higher conflicts in the areas of self-concept in patients with substance use disorder, as compared to control group. SACKS- SC guilt domain mean score for group A (patients with SUD) was 3.56 with SD of 1.75, for group B (control group), the mean score was 0.00 with SD 0.00. There was significant difference between the groups in terms of mean score SACKS-SC guilt domain (t= 14.372, p-value = 0.000). Mean scores were higher for SACKS-SC guilt domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of self guilt in patients with substance use disorder as compared to control group. SACKS-SC ability domain mean score for group A (patients with SUD) was 3.00 with SD of 1.54, for group B (control group), the mean score was 0.04 with SD 0.20. There was significant difference between the groups in terms of mean score SACKS-SC ability domain (t= 13.492, p-value = 0.000). Mean scores were higher for SACKS-SC ability domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of self-ability in patients with substance use disorder as compared to control group. SACKS-SC past domain mean score for group A (patients with SUD) was 1.18 with SD of 1.17, for group B (control group), the mean score was 0.02 with SD 0.14. There was significant difference between the groups in terms of mean score SACKS-SC past domain (t= 6.944, p-value = 0.000). Mean

scores were higher for SACKS- SC past domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of conflicts over past in patients with substance use disorder as compared to control group.

SACKS-SC future domain mean score for group A (patients with SUD) was 2.38 with SD of 1.84, for group B (control group), the mean score was 0.06 with SD 0.24. There was significant difference between the groups in terms of mean score SACKS-SC future domain (t= 8.844, p-value = 0.000). Mean scores were higher for SACKS-SC future domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of conflicts with future directions in patients with substance use disorder as compared to control group.

SACKS-SC goal domain mean score for group A (patients with SUD) was 2.30 with SD of 1.52, for group B (control group), the mean score was 0.00 with SD 0.00. There was significant difference between the groups in terms of mean score SACKS-SC goal domain (t= 10.733, p-value = 0.000). Mean scores were higher for SACKS-SC goal domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of conflicts over goal in patients with substance use disorder as compared to control group.

Table 18 and Figure 19 show the comparison between the scores of Motivational Needs, namely need for achievement (nAch), need for affiliation (nAff) and need for power (nPow). Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. nAch total mean score for group A (patients with SUD) was 3.14 with SD of 1.66, for group B (control group), the mean score was 6.59 with SD 1.23. There was significant difference between the groups in terms of total score nAch (t= -11.656, p-value = 0.000). Mean scores were higher for nAch total score in Group B as compared to Group A, which indicates that there is higher need for

achievement in control group, as compared to patients with substance use disorder. nAff total mean score for group A (patients with SUD) was 2.31 with SD of 1.47, for group B (control group), the mean score was 2.78 with SD 1.25. There was no significant difference between the groups in terms of total score nAff (t= -1.726, p-value = 0.088). Mean scores were higher for nAff total score in Group B as compared to Group A, which indicates that there is higher need for affiliation in control group, as compared to patients with substance use disorder. nPow total mean score for group A (patients with SUD) was 5.53 with SD of 1.68, for group B (control group), the mean score was 1.66 with SD 0.82. There was significant difference between the groups in terms of total score nPow (t= 14.569, p-value = 0.000). Mean scores were higher for nPow total score in Group A as compared to Group B, which indicates that there is higher need for power in patients with substance use disorder, as compared to control group.

Table 19 and Figure 20 show the comparison between the scores of parent child adult relationship score for mother form for the both the groups. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. PACQM total mean score for group A (patients with opioid use) was 24.04 with SD of 7.39, for group B (patients with alcohol use), the mean score was 21.92 with SD 5.48.There was no significant difference between the groups in terms of total score on mother domain (PCAQM) (t= 1.152, p-value = 0.255). PACQM (regard scale) mean score for group A was 10.68 with SD of 3.96, for group B, the mean score was 11.64 with SD 3.63.There was no significant difference between the groups in terms of score on regard domain of mother form (PCAQM- REG) (t= -0.894, p-value = 0.376). PACQM (responsibility scale) mean score for group A was 13.48 with SD of 4.93, for group B, the mean score was 10.28 with SD 4.70.There was significant difference between the groups in terms of score on responsibility domain of mother form (PCAQM- RES) (t= 2.351, p-value = 0.023). Where means scores for group A was higher as compared to group B, indicating that patients with opioid use

might feel more responsibility towards their mother than patients with alcohol use.

Table 20 and Figure 21 show the comparison between the scores of Sack's sentence completion test for Interpersonal area. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. SACKS-IR total mean score for group A (patients with opioid use) was 9.60 with SD of 3.98, for group B (patients with alcohol use), the mean score was 9.16 with SD 2.85. There was no significant difference between the groups in terms of total score SACKS-IR (t= 0.449, p-value = 0.655). Mean scores were higher for SACKS- IR total score in Group A as compared to Group B, which indicates that there is higher interpersonal conflict in patients with opioid use, as compared to patients with alcohol use. SACKS- IR relationship with friends domain mean score for group A (patients with opioid use) was 2.76 with SD of 1.20, for group B (patients with alcohol use) the mean score was 1.88 with SD 1.20. There was significant difference between the groups in terms of mean score SACKS-IR friends domain (t= 2.591, p-value = 0.013). Mean scores were higher for SACKS-IR friends domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in areas of relation with friends in patients with opioid use as compared to patients with alcohol use. SACKS-IR relationship with supervised domain mean score for group A (patients with opioid use) was 1.44 with SD of 1.42, for group B (patients with alcohol use), the mean score was 1.36 with SD 1.32. There was significant difference between the groups in terms of mean score SACKS-IR supervised domain (t= 0.207, p-value = 0.837). Mean scores were higher for SACKS-IR supervised domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in areas of relation with supervised in patients with opioid use as compared to patients with alcohol use.

SACKS-IR relationship with colleagues domain mean score for group A (patients with opioid use) was 0.72 with SD of 0.98, for group B

(patients with alcohol use), the mean score was 2.36 with SD 1.38. There was significant difference between the groups in terms of mean score SACKS-IR colleagues domain (t= -4.843, p-value = 0.000). Mean scores were higher for SACKS-IR colleagues domain total score in Group B as compared to Group A, indicating more interpersonal conflicts in areas of relation with colleagues in patients with alcohol use as compared to patients with opioid use.

SACKS-IR relationship with superiors domain mean score for group A (patients with opioid use) was 1.20 with SD of 1.22, for group B (patients with alcohol use), the mean score was 1.36 with SD 1.32. There was no significant difference between the groups in terms of mean score SACKS-IR supervised domain (t= 0.459, p-value = 0.648). Mean scores were higher for SACKS-IR superiors domain total score in Group B as compared to Group A, indicating more interpersonal conflicts in areas of relation with superiors in patients with alcohol use as compared to patients with opioid use. SACKS-IR fear domain mean score for group A (patients with opioid use) was 3.32 with SD of 2.17, for group B (patients with alcohol use), the mean score was 2.48 with SD 1.48. There was no significant difference between the groups in terms of mean score SACKS-IR fear domain (t= 1.599, p-value = 0.116). Mean scores were higher for SACKS-IR fear domain total score in Group A as compared to Group B, indicating more interpersonal conflicts in area of fear in patients with opioid use as compared to patients with alcohol use.

Table 21 and Figure 22 show the comparison between the scores of Sack's sentence completion test for Self-concept area. Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. SACKS-SC total mean score for group A (patients with opioid use) was 12.48 with SD of 3.81, for group B (patients with alcohol use), the mean score was 12.24 with SD 2.96. There was no significant difference between the groups in terms of total score SACKS-IR (t= 0.249, p-value = 0.805). Mean scores were

higher for SACKS- SC total score in Group A as compared to Group B, which indicates that there are higher conflicts in the areas of self-concept in patients with opioid use as compared to patients with alcohol use. SACKS- SC guilt domain mean score for group A (patients with opioid use) was 4.28 with SD of 1.70, for group B (patients with alcohol use), the mean score was 2.84 with SD 1.52. There was significant difference between the groups in terms of mean score SACKS-SC guilt domain (t= 3.162, p-value = 0.003). Mean scores were higher for SACKS-SC guilt domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of self-guilt in patients with opioid use as compared to patients with alcohol use. SACKS-SC ability domain mean score for group A (patients with opioid use) was 2.72 with SD of 1.72, for group B (patients with alcohol use), the mean score was 3.28 with SD 1.31. There was no significant difference between the groups in terms of mean score SACKS-SC ability domain (t= -1.296, p-value = 0.201). Mean scores were higher for SACKS-SC ability domain total score in Group B as compared to Group A, indicating higher conflict in the areas of self-concept, further in areas of self-ability in patients alcohol use as compared to patients with opioid use. SACKS-SC past domain mean score for group A (patients with opioid use) was 1.20 with SD of 1.26, for group B (patients with alcohol use), the mean score was 1.16 with SD 1.11. There was no significant difference between the groups in terms of mean score SACKS-SC past domain (t= 0.119, p-value = 0.905). Mean scores were higher for SACKS- SC past domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of conflicts over past in patients with opioid use as compared to patients with alcohol use.

SACKS-SC future domain mean score for group A (patients with opioid use) was 2.00 with SD of 1.87, for group B (patients with alcohol use), the mean score was 2.76 with SD 1.76. There was no significant difference between the groups in terms of mean score SACKS-SC future domain (t= -1.478, p-value = 0.146). Mean scores were higher

for SACKS-SC future domain total score in Group B as compared to Group A, indicating higher conflict in the areas of self-concept, further in areas of conflicts with future directions in patients alcohol use as compared to patients with opioid use. SACKS-SC goal domain mean score for group A (patients with opioid use) was 2.40 with SD of 1.85, for group B (patients with alcohol use), the mean score was 2.20 with SD 1.12. There was no significant difference between the groups in terms of mean score SACKS-SC goal domain (t= 0.462, p-value = 0.646). Mean scores were higher for SACKS-SC goal domain total score in Group A as compared to Group B, indicating higher conflict in the areas of self-concept, further in areas of conflicts over goal in patients with opioid use as compared to patients with alcohol use.

Table 22 and Figure 23 show the comparison between the scores of Motivational Needs, namely need for achievement (nAch), need for affiliation (nAff) and need for power (nPow). Since both the groups were normally distributed, thus parametric tests (t-test) was used to make the comparisons. nAch total mean score for group A (patients with opioid use) was 3.33 with SD of 1.76, for group B (patients with alcohol use), the mean score was 2.83 with SD 1.58. There was no significant difference between the groups in terms of total score nAch (t= 0.785, p-value = 0.437). Mean scores were higher for nAch total score in Group A as compared to Group B, which indicates that there is higher need for achievement in patients with opioid use, as compared to patients with alcohol use. nAff total mean score for group A (patients with opioid use) was 2.83 with SD of 1.58, for group B (patients with alcohol use), the mean score was 1.80 with SD 1.19. There was no significant difference between the groups in terms of total score nAff (t= 2.594, p-value = 0.013). Mean scores were higher for nAff total score in Group A as compared to Group B, which indicates that there is higher need for achievement in patients with opioid use, as compared to patients with alcohol use. nPow total mean score for group A (patients with SUD) was 4.79 with SD of 1.69, for group B (control group), the mean score was 6.46 with SD 1.36. There was significant difference

between the groups in terms of total score nPow (t= -3.305, p-value = 0.002). Mean scores were higher for nPow total score in Group A as compared to Group B, which indicates that there is higher need for power in patients with alcohol use, as compared to patients with opioid use.

DISCUSSION

The present study was conducted to study the difference between parental relationship, attributional bias, motivational needs and types of conflicts in young adults with and without substance use disorder. The study is different in the sense that it focuses on assessing the, parental relationship in terms of regard, responsibility and control, motivational needs and types of conflicts in young adults with substance use disorder, which will help in making holistic family intervention plans for rehabilitation and relapse prevention.

The study also examined whether there are any differences regarding the above variables in the two substance use groups, i.e., patients with alcohol use and patients with opioid use.

In the present study 100 participants were included, out of which 50 were patients who had substance use disorder (25 were patients with opioid use and 25 were patients with alcohol use) and 50 participants comprised of control group. Parental relationship was assessed by using the parent adult-child relationship questionnaire (PACQ), attributional bias by using internal, personal and situational attribute questionnaire (IPSAQ), motivational needs by using motivational questionnaire and types of conflicts by administering sacks sentence completion test (SSCT).

SOCIO DEMOGRAPHIC ATTRIBUTES

AGE

In the present study the age range for study was 18-35 years of age. The study group comprised of 58% of subjects of age group 30-35 years which is in line with the previous studies of Merline et al. (2004)[132] where it was reported that adults of age 35 years were using illicit drug at a rate higher than expected and more than 32% adults in the study reported heavy alcohol use in the past 2 weeks. Our findings are also in line with another study done by Bharat et al, 2017[133], where the majority of substance users were in the age group 26-35 years. The mean age was 29 years for the study group which is also in line

with the results from the 2013 National Survey on Drug Use and Health: Summary of National Findings[134] where 7.3% people reported illicit drug use in 2013 in age group 26 years and older. In the control group the mean age was 27 years with 54% of individuals being in the age group of 24-29 years, 22% in the age group of 18-23 years and 24% in the age group of 30-35 years. There was a significant difference in the mean ages of both the groups. The differences in the two groups could be the outcome of increased responsibility in the study group, parental responsibilities, job pressure which tend to play a role in turning towards substance use for coping.

DRUG USE

In the current study, of 50 individuals having SUD, 50% had alcohol use disorder and 50% had opioid use disorder. The investigator was unable to find similar relation in studies done in the past where the sample group was of the same size.

BACKGROUND

In the current study, the distribution of participants in terms of background was seen in terms of living in urban and rural area. In the study group 76% reported living in urban area and 34% in rural areas which is in line with the previous studies by Mueser, et al., 2001[135], where it was demonstrated that drug abuse was higher in urban population as compared to rural population. The above studies are also in line with the studies of Ompad, Danielle & Fuller, Crystal (2005)[136] and Bharat et al, 2007[133]. In the control group, total subjects were from urban background. The investigator was unable to find similar relation in studies done in the past.

MARITAL STATUS

In the present study, distribution of participants according to family type included 90% of subjects as married in the study group whereas 10% of subjects were single which is in line with the previous studies of Leonard and Homish, 2005[137] where it was found that 19.7% of wives and 25.5% of husbands reported increased drug abuse in the first year

after marriage. The above results are also in line with the studies of Merline et al.; 2004[132] and statistics from Substance Abuse and Mental Health Services Administration, National survey on drug use and health, 2003[138]. The control group comprised of 91% subjects as single while 9% as married. The investigator was unable to find similar relation in studies done in the past.

FAMILY TYPE

In the current study, distribution of participants in terms of Family Type in the study group, where54% of subjects were of a nuclear family and 46% were from a joint family which is in line with the previous study of and also the study of Bharat et al, 2017[132] where around 54% subjects belonged to nuclear family and 46% belonged to joint family type. In another study by Liza et al, 2017 [139] it was found that substance use among nuclear family type was 67% while in joint family type was that of 32%.In the control group, 88% were from nuclear family while 12% were from joint family. The investigator was unable to find similar relation in studies done in the past.

PARENTAL RELATIONSHIP

In our study the mean score for regard scale for relationship with mother and father, responsibility scale for father was higher for control group as compared to patients with substance use disorder showing, that patients with substance use disorder have less attachment or care, filial gratitude and closeness. Their parents might show less appreciation towards their children and also have negative appraisals and also do not acknowledge the caretaking efforts. Or we can put this the other way in terms of reciprocity- a concept by Cicerelli (1983), which is consistent with studies done by Skeer et al., 2011[140] where they found highly conflictual family relationships were associated with substance use disorders in late adolescence and early adulthood. The results are also consistent with the study of Sylvie Ledoux et al, 2002 where they found out that adolescents who lived in non-intact families were more likely to use alcohol, tobacco or illicit drugs.[141]

Young adults also feel the need for support and validation from their parents which might be less. These findings are also consistent with previous studies of J. Brook, Gordon, Whiteman, & Cohen, 1986[142]; Chilcoat & Anthony, 1996[108], where increased risk of substance abuse included poor and inconsistent family management practices, lack of or inconsistent discipline, poor monitoring of behaviour, excessive punishment, a hostile environment, family conflict, and poorer parent–child interactions.

In our study we also found that young adults who had substance use disorder also had lower mean scores for responsibility towards father as compared to control group which indicates that they might have less adult feelings of guilt, burden and protectiveness, elements of parentification and the desire to compensate for the parent's past suffering (Boszormenyi-Nagy & Spark, 1984[143]; Whittick[144].The mean score for control domain for father was higher in patients with substance used disorder as compared to control group which shows that they might feel more parental power over the life cycle, which is an important factor in childhood (Minuchin, 1974[145]; Murphy et al., 1997[146], parental power diminishes over time (Benbow et al., 1990[147]; Carter & McGoldrick, 1980[148] as most parents gradually view their children more as friends than subordinates (Blieszner & Mancini, 1987[149], which in our sample is reflected in a way as the parents still tend to exhibit parental control over children and might not regard them as friends, in turn leading to increased risk of substance use.

These findings are in line with previous studies of Becoña E, Martínez Ú, Calafat A, et al, 2003[90] who found out that children belonging to authoritarian parents showed more patterns of substance abuse in comparison to children of authoritarian parents. The above findings are also in line with study of Costa et al, 2019 [86] which stated that parents showing higher psychological control, their children are at an increased risk of abusing tobacco, alcohol and other illicit drugs. (Kincaid et al. 2011[87]; Romm and Metzger 2018[88]

In our study it was also found on comparing the parental relationship between the patients with opioid use and alcohol use, the mean score for responsibility domain of relationship with mother was higher for the opioid group as compared to alcohol group. The investigator was unable to find similar relation in studies done in the past.

ATTRIBUTIONAL BIAS

In our study there were no significant differences found between the patients with substance use disorder and control group for externalizing bias and personalizing bias. But there was significant difference found between the two groups for the external personal attribution for negative events domain, for which mean score was lower for patients with substance use as compared to control group, indicating that patients with substance use disorder tend to make internal attributions for negative events and attribute the negative events less to external causes, which is in line with the study of Kingree, Sullivan & Thompson (1999)[59] where they studied the individuals enrolled in a 12 step residential treatment program for substance use, the participants were assessed at the time of admission and at 2 months follow up where it was found that both the time the addictive behaviour was attributed to personal causes, in support of the above findings of our results, there was a increase in personal attribution with a decrease in situational attribution at the two months follow-up.

Our study also found significant difference in external situational attribution for positive events domain, where mean score was higher for ESA-P for substance use group which shows that patients with substance use problem tend to attribute the positive events to external causes or make situational attributions for positive events, which is in line with the study of Baumann, Donald & Obitz, Frederick & Reich, John. (1982).[150] Where late treatment alcoholic subjects made dispositional attributions to other alcoholics and made situational attributions for their abstinent behaviour, i.e.; their abstinence was considered as a part of the awareness about their drug problem in the

course of treatment which resulted in attributing the positive abstinent situation to external causes.

MOTIVATIONAL NEEDS

In our study it was found that there was significant difference between the need for achievement between both the groups. The mean score for nAch was low for substance use group as compared to control group, which is consistent with the findings of the studies by R. G. Cox, L. Zhang, W. D. Johnson, and D. R. Bender[151] where they found that adolescent students who used different substances were poor academic achievers. In another study by Meressa, et al.[152] It was seen substance use was associated with low academic performance. In another study by Kate et al. 2008[153] it was found that risk for adult drug use was related to underachievement in 1st grade, low 7th and 8th grade scores. The findings are also consistent with the studies of McClelland, 1972[125] and Bársonya et al, 2013[126].

In our study we also found that there was significant difference in the mean scores of need for power for both the groups, which was higher for the substance use group, there was also significant difference for the mean scores for nPow, between the patients with opioid use and alcohol use, with higher mean scores for nPow in patients with alcohol use. These findings are in line with the previous studies done by McClelland et al. (1972)[125] who found more affiliation and power need notions but less achievement need notions in marijuana and LSD users' narratives for TAT pictures. They also found that drug use in youth is a type of expression of personal power needs or rebellion. In our study there was also significant difference found in the mean scores for nAff on comparing opioid use group and alcohol use group, where means scores were higher for opioid use group than alcohol use group which is consistent with the study conducted by. (Bársonya et al. (2013)[126] where it was found that opioid dependent individuals had higher needs for affiliation and lower needs for achievement.

TYPES OF CONFLICT- FAMILY AREA

In our study we found that there was significant difference in the mean scores of different types of conflicts measured by Sack's sentence completion test, namely, conflicts in family area, sex area, interpersonal area and self-concept areas between the substance abuse group and control group. The mean scores for above mentioned areas were higher in substance use group as compared to healthy control group. These results are in line with the previous studies done by Vakalahi HF, 2001 and Madu SN, Matla MP, 2003[75-76], where they found that family environments with high levels of adversity, including violence, stress, parental drug use, ineffective communication and discipline, and poor sibling relationships, have been linked to adolescent drug use. Another study by Rhodes and Jason (1990)[100]demonstrated that poor family environments (i.e., poor parental relationships, a high degree of family problems) were significantly associated with a higher level of drug use.

The above results are also in line with previous studies by Englund et al., 2008[154]; Fergusson et al., 2007[155]; Shelton and Harold, 2008[156]; Zucker, 2008[157].

SEX AREA

In one study by Amato & Previti, 2003[47]; Halford & Osgarby, 1993[48]; Wilsnack, 1996[49] it was found that alcohol abuse was shown to be both a precipitant and consequence of marital stress, spousal abuse, and separation and divorce. Stressful marital interactions are associated with exacerbation of alcohol abuse and failed abstinence (Halford & Osgarby, 1993;[48] Kahler, McCrady, & Epstein, 2003[51].

In one study by Antonio et al, 2012[158], it was seen that drug users had difficulty establishing deep and committed relationship with partners, showed signs of inhibition, affective detachment and anger. Their sexual lives also had increased negative emotions, maladjusted behaviours with disturbing thoughts.

INTERPERSONAL AREA

Mean score for interpersonal conflicts was also high in substance abuse group indicating significant increased conflicts in the domains of friends, with supervised, colleagues, superiors and fear; which is in line with the previous studies done by Reaney, Martin, &Speight, 2008[111], which showed that patients with substance abuse are at risk of experiencing significant interpersonal distress.

SELF CONCEPT AREA

There was also higher mean score in our study for self-concept area in patients with substance use which shows that patients have higher conflicts in domains of guilt, past, future, self-ability and goal. The findings are consistent with previous studies by Kounenou, 2010 who found that increased self-esteem is the predictor of avoidance of drugs and narcotics.[117] Kahn reported that lack of self-esteem can be correlated with increase in likelihood of drug abuse. Guglielmo et al., 1985 reported that low self-esteem is correlated with drug use.[118] Feltis, 1991 reported that there was a very strong negative correlation between trend of drug use and amount of self-esteem in adolescents[119]. Smart and Ogborne, 1994 reported that youths under treatment for drug abuse had lower self-esteem.[120] Emery et al., 1993 found that student's self-esteem (at home or at school) is reversely correlated with drug use (illegal substances and drugs), tobacco and alcohol.[121] In another study by Cook 2006[159], it was found that heightened feelings of guilt and shame was related to increased vulnerability to addictive behaviours like substance use. In other studies by Abramowitz & Berenbaum, 2007[160]; Dearing, Stuewig & Tangney, 2005[161] reported significant relation between shame, guilt and maladaptive behaviours which included substance use.

Other studies by Charalampous, Ford, and Skinner; 1976[162] stated that self-esteem has plays an important role in the use of alcohol and psychoactive substances. Mitic, 1980[163]; Yanish, and Battle 1985 [164] concluded in their study that low self-esteem poses higher risk for

substance use. Ward in his study in 1995 found that lack of conformity and low self-esteem was found to be high risk factors for tobacco, alcohol and other drug uses in adolescents.

In one study by Aleena Akhtar, 2013[165] on relationship between substance use and self-esteem, she also found that drug abusers attributed the following reasons as causes of drug abuse like conflictual family relation and family problems, failed love affairs and lack of social and family support. In the same study it was also concluded that drug abuse may lead to lower self-esteem.

Other studies by Baler and Volkow, 2006[166], Ford and Blumenstein, 2012[167], Kadden and Litt, 2011[168] and Wienberg, 2013[169] have also found that substance abuse could also modify neural states and result in disruption of individuals self-control and self-efficacy capabilities.

LIMITATIONS

- Our study was conducted on a small sample of SUD patients which is not representative of the total SUD population. More sample size would help in better estimation regarding the variables in study.
- Our study included only alcohol and opioid use patients. Other substances were not included in the study. Hence, the comparison done is only restricted to two groups.
- The study was conducted only on male addicts which again poses a problem in the generalization of the results.

SUMMARY AND CONCLUSION

The present study focuses on the comparison between parental relationship, attributional bias, motivational needs and types of conflict in young adults with and without substance use disorder. In the present study the following points were noted:

- Age group for both the study group and control group was 18-35 years of age, with majority of individuals in study group were in the age range of 30-35 years, whereas in the control group were in the age range of 24-29 years.
- Mean age for study group was 29.34 years and for control group was 27.28 years.
- In terms of drug use, 25 individuals were alcohol users and 25 individuals were opioid users.
- In terms of background 76% were from urban background and 24% were from a rural background in the study group. In the control group 100% population was from urban background.
- In terms of marital status, 90% were married and 10% were single in study group, while in control group, 91% were single and 9% were married individuals.
- In terms of family type, 54% were from a nuclear family and 46% were from a joint family. In the control group, 88% were from a nuclear family and 12% were from a joint family.
- There was significant differences in the mean score for different factors of parental relationship for both mother and father scale.
- There was significant difference for mean score for the regard factor for mother subscale, with a higher mean score in control group than the study group, indicating that controls had much regard for mothers as compared with individuals with substance use.
- There was significant difference for regard, responsibility and control factor for father scale. Mean scores were higher for regard and responsibility factor for control group as compared to study group, indicating lower regard and responsibility towards

father in the study group which indicates that individuals with substance use disorder have less attachment or care, filial gratitude and closeness with their parents. Mean score for control scale is higher in study group as compared to control group showing increased feeling of parental power in one's life in individuals with SUD.

- There was also observed significant difference between the mean scores of responsibility factor on mother scale between individuals with alcohol use and opioid use, with higher mean score in opioid users.
- There was observed significant difference in the mean scores of EPA for negative events with a higher mean score in the control group.
- There was observed significant difference in the mean score for achievement need, where mean score was higher in control group than study group showing decreased need for achievement in individuals with SUD.
- There was observed significant difference in the mean score for power need, where mean score was higher in study group than control group showing increased need for power in individuals with SUD.
- There was observed significant difference in the mean score for power need, where mean score was higher in individuals with opioid use than individuals with alcohol use showing increased need for affiliation in individuals with opioid use.
- There was observed significant difference in the mean score for power need, where mean score was higher in individuals with alcohol use than individuals with opioid use showing increased need for power in individuals with alcohol use.
- In the present study there was observed significant difference in the total scores of SSCT, where mean score was higher in study group than control group showing more conflicts in all the four areas in individuals with SUD.

- In the present study, there was observed significant difference in the mean score of family area, with greater mean score for study group as compared to control group showing more conflicts in the family area in individuals with SUD.
- In the present study there was observed significant difference in the mean scores of sex area, where mean score was higher in study group than control group showing more conflicts in sex area in individuals with SUD.
- In the present study, there was observed significant difference in the mean score of interpersonal area, with greater mean score for study group as compared to control group showing more conflicts in the interpersonal area in individuals with SUD.
- In the present study, there was observed significant difference in the mean score of self-concept area, with greater mean score for study group as compared to control group showing more conflicts in the self-concept area in individuals with SUD.
- In the present study, there was observed significant difference in the mean score of subscale- friends in interpersonal area, with greater mean score for opioid users as compared alcohol users showing more conflicts in individuals with opioid use.
- In the present study, there was observed significant difference in the mean score of subscale-colleagues in interpersonal area, with greater mean score for alcohol users as compared opioid users showing more conflicts in individuals with alcohol use.
- In the present study, there was observed significant difference in the mean score of subscale- guilt in self-concept area, with greater mean score for opioid users as compared alcohol users showing more conflicts in individuals with opioid use.

Hence in our study there were significant differences found in parental relationship, motivational needs and types of conflict between study group (individuals with substance use disorder) and control group (healthy individuals from general population). It was observed that there were higher conflicts in individuals with SUD compared to healthy

individuals, rearing practices, attachment style and support by parents play a very important role in making individuals vulnerable to drug use. It was also seen that the study group had heightened needs for power which indicate that they might have controlling parents which was also seen in our study that control factor was higher for study group. There was no significant difference observed in attributional bias in between the two groups, but the mean score for personalizing bias was higher in study group which is in line with the previous studies where it was found that individuals with problems like depression, substance use have internal or personalizing bias.

In order to form a family based intervention for rehabilitation of young adults, we could take the above variables into consideration, address their conflicts in the four areas, evaluate their needs, address the negative bias through cognitive restructuring and help parents know about their role in helping the individuals to leave the substance and how their support, attachment and parental control could affect the healing process.

FUTURE DIRECTIONS

- Further in the study a larger sample can be employed including both males and females for better results.
- The studies in future could also include assessment of coping strategies, defence mechanism, caregiver burden, emotional regulation, quality of life and need assessment of the caregiver as well.
- Future studies could be done on planning and applying intervention strategies, keeping in mind the above four variables and hence seeing the pre and post effects.

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KEY TO MASTER CHART

PATIENT

AGE:

1=18-23 YEARS

2=24-29 YEARS

3=30-35 YEARS

DRUG:

O= OPIOID

A= ALCOHOL

BACKGROUND

1=RURAL

2=URBAN

MARITAL STATUS

S=SINGLE

M=MARRIED

FAMILY TYPE

1=JOINT

2=NUCLEAR

CONTROL

AGE:

1=18-23 YEARS

2=24-29 YEARS

3=30-35 YEARS

BACKGROUND

1=RURAL

2=URBAN

MARITAL STATUS

S=SINGLE

M=MARRIED

FAMILY TYPE

1=JOINT

2=NUCLEAR

S.NO	MRD	NAME	AGE	DRUG=O/A	RURAL =1/ URBAN=2	SINGLE/ MARRIED	JO=1I/ NUC=2	IA-P	IA-N	EPA-P	EPA-N	ESA-P	ESA-N	PACQ-M	PACQ-F	PACQ-M (REG)	PACQ-M(RES)	PACQ-F(REG)	PACQ-F(RES)	PACQ-F (CON)	SACS	SACKS-FA	MOTHER	FATHER
1	978016	AK	30	O	2	M	2	11	4	2	6	3	6	34	38	15	19	12	12	14	23	4	0	4
2	197930	TS	32	O	1	M	2	5	13	8	2	3	1	1	14	1	0	1	0	13	57	21	7	8
3	509714	AS	35	O	1	M	1	8	6	4	2	4	8	30	27	10	20	11	4	12	16	3	1	0
4	825042	AK	26	O	2	M	1	6	7	2	1	8	8	30	25	12	18	9	8	8	25	4	1	1
5	757791	A	22	O	2	M	1	10	13	3	2	3	1	16	24	4	12	12	2	10	39	16	3	5
6	155791	GS	25	O	2	S	2	5	7	7	6	4	3	27	31	12	15	12	11	8	24	3	0	3
7	452646	DS	32	O	1	M	1	13	12	1	1	2	3	27	25	18	9	6	10	9	30	8	1	3
8	957312	MS	30	O	1	M	1	7	10	8	3	1	3	25	21	10	15	10	7	4	34	8	1	2
9	1006210	Y	32	O	2	M	2	10	0	4	10	2	6	32	16	18	14	6	4	6	28	8	0	4
10	224126	PS	29	O	2	S	2	9	9	4	4	3	3	18	21	8	10	9	3	9	21	2	0	2
11	94678	DS	35	O	1	M	2	9	2	6	10	1	4	27	30	11	17	5	13	12	19	4	1	3
12	786379	JS	18	A	2	S	2	3	10	5	3	8	3	16	15	6	10	7	4	4	36	12	4	6
13	990593	NS	32	O	2	M	1	10	8	1	4	5	4	34	30	14	20	12	9	9	33	8	1	5
14	1005207	HS	24	O	2	M	1	7	7	6	3	3	6	23	28	8	15	12	12	4	32	9	5	1
15	633131	CD	26	O	2	M	1	12	6	2	0	2	10	27	21	15	12	11	10	0	32	4	0	2
16	1010309	JNG	32	A	2	S	2	5	4	3	6	6	6	23	26	19	4	10	6	10	28	13	4	2
17	723062	PJ	30	O	2	M	2	11	2	2	10	3	4	19	11	6	13	3	1	7	28	5	0	3
18	1013148	H	21	O	2	M	1	3	3	8	9	5	4	30	31	12	18	12	7	12	36	6	0	4
19	974247	AD	25	O	2	S	2	8	4	3	7	5	5	26	36	14	12	13	10	13	34	4	0	2
20	971304	SS	27	O	1	M	1	10	7	4	6	2	3	17	25	8	9	8	3	14	26	5	0	3
21	45612	HS	24	O	2	M	1	7	9	3	5	6	2	22	30	10	12	6	10	14	36	6	1	3
22	670892	G	27	O	2	M	1	13	6	2	5	1	5	15	27	11	4	9	7	11	27	4	1	2
23	967400	JS	33	O	2	M	2	8	10	2	2	6	4	26	32	10	16	12	7	13	22	2	0	1
24	925817	MS	35	O	1	M	2	6	3	4	9	6	4	32	15	12	20	2	3	9	33	6	3	2
25	924457	NS	25	O	1	S	2	9	8	3	5	4	3	22	27	9	11	8	7	12	28	10	3	3
26	924775	V	19	O	2	S	2	4	9	7	3	5	4	18	22	12	10	10	4	8	28	4	1	2
27	923478	RS	21	A	2	S	2	6	11	4	4	6	2	25	20	10	15	5	7	8	30	5	2	2
28	921478	MS	35	A	2	M	1	8	4	3	7	5	5	17	26	12	5	8	5	12	38	8	2	4
29	921925	G	29	O	1	M	1	3	9	5	3	7	4	23	29	7	16	12	6	11	29	8	0	6
30	921445	KM	30	A	2	M	2	11	5	3	4	2	7	10	16	7	3	2	5	9	47	15	5	7
31	921586	NT	27	A	2	M	2	5	12	7	3	5	1	24	28	9	15	7	7	14	25	3	0	2
32	915236	MK	30	A	2	M	1	7	4	5	7	4	5	19	23	7	12	6	8	9	23	2	1	1
33	889346	GM	33	A	2	M	1	3	11	7	4	6	1	18	27	12	6	5	9	14	35	4	1	2
34	759012	CS	34	A	2	M	1	6	8	6	3	4	5	20	29	15	5	9	9	11	23	3	0	3
35	906471	MS	30	A	2	S	2	9	5	3	7	4	4	26	30	17	9	10	7	13	34	6	1	3
36	902804	SS	33	A	1	M	1	7	9	5	4	3	3	17	19	11	6	3	7	9	27	2	0	1
37	764314	SS	24	A	2	M	2	12	4	3	5	1	7	23	27	8	15	7	0	10	25	4	0	3
38	898902	PS	35	A	2	M	2	5	8	6	2	5	6	12	18	8	4	5	6	7	30	2	1	1
39	882613	MS	35	A	2	M	2	7	4	3	4	6	8	24	25	13	11	4	13	8	19	5	2	2
40	601460	HS	32	A	2	S	1	8	4	3	7	5	5	29	24	11	18	5	8	11	28	6	4	1
41	983962	SS	24	A	2	M	2	5	8	7	4	4	4	27	31	12	15	10	9	12	33	2	1	0
42	798542	HS	26	A	2	M	1	3	10	6	2	7	4	19	25	13	6	7	7	11	26	5	1	2
43	1014169	PS	32	A	1	M	1	6	8	6	2	4	6	25	23	11	14	8	6	9	20	4	3	1
44	844048	MS	25	A	1	M	1	4	9	7	3	5	4	26	32	18	8	12	8	12	30	6	1	4
45	858032	DK	34	A	2	M	2	12	8	1	3	3	5	22	28	9	13	11	7	10	28	3	0	2
46	831120	IS	35	A	2	M	2	7	5	5	8	4	3	15	23	9	6	8	7	8	23	2	0	2
47	875274	JS	35	A	2	M	1	5	6	9	7	2	3	27	29	11	16	12	8	9	20	4	1	3
48	365113	GS	34	A	2	M	2	5	9	7	3	4	4	25	29	10	15	11	6	12	22	2	0	1
49	920517	RS	35	A	2	M	2	6	3	5	5	5	8	26	33	16	10	8	9	9	34	6	1	4
50	758994	VA	33	A	2	M	2	12	5	3	7	1	4	33	37	17	16	13	10	14	32	6	2	3

S.NO	MRD	FAMILY UNIT	SACKS-SA	FEMALE	OPP SEX	SACS-IR	FRIENDS	SUPERVISED	COLLEAGUES	SUPERIORS	FEAR	SACKS-SC	GUILT	ABILITY	PAST	FUTURE	GOAL	MQ-ACH	MQ-AFF	MQ-POW
1	978016	0	0	0	0	9	2	4	1	1	1	10	7	1	0	0	2	6	4	1
2	197930	6	6	4	2	10	4	0	2	2	2	20	4	4	2	6	5	2	1	8
3	509714	2	3	3	0	7	2	3	0	2	0	4	1	0	1	1	0	5	3	3
4	825042	3	2	1	1	7	3	2	0	0	2	12	4	5	0	2	1			
5	757791	8	1	0	1	8	2	1	2	3	0	14	4	3	3	0	4	1	5	5
6	155791	0	2	2	0	8	1	0	1	0	6	11	5	1	3	2	0	5	3	3
7	452646	4	1	0	1	8	3	2	2	0	1	13	3	5	2	0	3	2	4	5
8	957312	5	2	2	0	20	5	4	0	4	7	11	8	3	0	0	0	6	3	2
9	1006210	4	2	2	0	11	3	2	2	0	4	6	2	2	0	2	0	1	3	6
10	224126	0	3	2	1	4	1	1	0	0	2	12	6	3	2	0	1	4	2	5
11	94678	0	0	0	0	1	1	0	0	0	0	14	5	4	2	0	3	0	6	5
12	786379	2	2	2	0	7	2	1	1	0	3	15	6	5	3	0	1	0	3	8
13	990593	2	1	1	0	15	5	2	0	2	8	19	6	4	4	4	5	2	5	4
14	1005207	3	2	2	0	10	4	0	1	1	4	11	4	4	0	0	2	7	2	2
15	633131	2	3	3	0	9	1	3	0	2	3	16	6	4	3	2	1	3	1	7
16	1010309	7	1	1	0	6	1	2	1	0	2	8	2	2	0	1	3	0	4	7
17	723062	2	3	1	2	10	3	1	0	1	5	10	4	3	2	0	1	2	5	4
18	1013148	2	0	0	0	12	3	0	2	2	5	18	3	6	1	4	4	4	1	6
19	974247	1	0	0	0	16	4	2	3	1	6	14	6	0	0	4	4	3	2	6
20	971304	2	1	1	0	8	2	3	0	0	3	12	4	4	0	2	2	4	1	6
21	45612	2	2	1	1	11	3	1	0	3	4	17	4	2	2	4	5	2	4	5
22	670892	2	1	1	0	9	4	0	0	0	5	13	6	0	0	3	4	4	0	7
23	967400	1	3	2	1	7	3	0	0	2	2	10	4	1	0	3	2	4	3	4
24	925817	1	4	2	2	8	4	0	0	0	2	15	3	0	0	6	6	3	2	6
25	924457	4	0	0	0	5	2	0	0	0	3	13	4	3	1	2	3	5	1	5
26	924775	1	1	1	0	14	2	1	2	1	4	9	2	3	0	2	2	3	3	5
27	923478	1	1	0	1	8	2	0	3	0	3	16	3	4	1	5	3	2	2	7
28	921478	2	4	3	1	15	3	2	4	2	4	11	1	4	2	1	3	6	2	3
29	921925	2	0	0	0	13	2	4	0	3	4	8	2	3	2	1	0	2	4	5
30	921445	3	4	2	2	11	3	1	4	1	2	17	4	1	3	5	4	2	2	7
31	921586	1	3	3	0	7	1	2	3	0	1	12	3	4	0	2	3	3	1	7
32	915236	0	1	1	0	5	3	1	0	0	1	15	2	5	1	4	3	2	1	8
33	889346	1	1	0	1	12	1	4	5	0	2	18	6	4	2	5	1	3	3	5
34	759012	0	0	0	0	9	3	1	2	2	1	11	0	5	2	2	2	3	2	6
35	906471	2	3	2	1	13	0	4	4	0	5	12	3	4	0	0	5	1	4	6
36	902804	1	1	1	0	10	0	2	2	1	5	14	5	3	0	6	0	3	1	7
37	764314	1	4	3	1	7	1	2	2	1	1	10	3	2	2	1	2	4	0	7
38	898902	0	3	2	1	11	2	0	4	3	2	14	4	4	0	5	1	4	2	5
39	882613	1	0	0	0	5	1	0	3	1	0	9	3	1	1	3	1	2	4	5
40	601460	1	4	2	2	8	1	4	2	0	1	10	2	2	3	1	2	3	1	7
41	983962	1	3	2	1	13	3	1	3	1	5	15	4	3	1	4	3	3	0	8
42	798542	2	1	0	1	9	2	0	2	4	1	11	1	4	2	2	2	6	1	4
43	1014169	0	2	2	0	6	1	0	0	2	3	8	2	2	1	1	2	5	1	5
44	844048	1	0	0	0	11	3	0	1	2	5	13	4	4	0	3	2	2	3	6
45	858032	1	2	0	2	7	2	2	0	0	3	16	3	2	3	5	3	2	1	8
46	831120	0	0	0	0	12	0	3	2	4	3	9	1	4	0	2	1	4	1	6
47	875274	0	3	2	1	5	1	0	2	1	1	8	3	1	1	2	1	3	3	5
48	365113	1	0	0	0	9	3	1	2	0	2	11	1	4	1	4	2	5	1	5
49	920517	1	3	3	0	11	4	0	3	1	3	13	2	5	0	3	3	2	1	8
50	758994	1	4	1	3	12	4	1	4	0	3	10	3	3	0	2	2	4	1	6

S.NO	NAME	AGE	RURAL/ URBAN=1/2	SINGLE/ MARRIED	JO=1I/ NUC=2	IA-P	IA-N	EPA-P	EPA-N	ESA-P	ESA-N	PACQ-M	PACQ-F	PACQ-M (REG)	PACQ-M(RES)	PACQ-F(REG)	PACQ-F(RES)	PACQ-F (CON)	SACS	SACKS-FA
1	SYJ	22	2	S	2	11	6	3	4	2	6	20	26	12	8	12	8	6	0	0
2	DS	23	2	S	2	9	5	5	6	2	5	17	20	9	8	8	7	5	0	0
3	JK	23	2	S	2	6	7	7	5	4	4	22	26	13	9	12	7	5	0	0
4	AV	29	2	S	2	8	4	5	6	3	6	28	30	17	11	11	9	8	0	0
5	AV	26	2	M	2	10	6	3	4	3	6	23	24	14	9	11	9	4	2	0
6	A	28	2	S	2	9	8	6	5	1	3	15	20	8	7	9	8	2	4	0
7	SJD	32	2	S	2	4	10	7	3	5	3	27	29	15	12	10	11	8	3	0
8	SG	30	2	S	2	7	5	6	7	3	4	29	26	16	13	11	9	6	0	0
9	AS	27	2	S	2	8	7	4	6	4	3	19	21	11	8	9	15	3	0	0
10	AS	29	2	S	2	12	5	3	4	1	7	22	28	13	9	9	12	7	1	0
11	SSS	23	2	S	2	8	9	5	5	3	2	25	29	11	14	12	12	5	0	0
12	DB	25	2	S	2	6	6	6	8	4	2	20	24	13	7	9	8	7	0	0
13	KR	22	2	S	2	7	6	5	5	4	5	27	29	15	12	9	11	9	0	0
14	RK	32	2	S	2	11	7	2	6	3	3	21	25	13	8	8	11	6	0	0
15	NK	35	2	M	2	8	5	5	9	3	7	30	27	18	12	12	10	5	0	0
16	SD	25	2	S	2	10	3	2	7	4	6	27	25	16	11	11	9	5	0	0
17	SSS	26	2	S	2	7	6	8	5	1	5	25	28	15	10	12	9	7	0	0
18	PK	28	2	S	2	8	4	5	6	3	6	21	24	12	9	10	8	6	1	1
19	TS	35	2	M	2	8	7	3	5	5	4	29	26	15	14	9	11	6	1	0
20	AS	32	2	M	2	11	3	2	7	3	6	26	28	15	11	12	10	6	3	0
21	I	28	2	S	2	6	9	7	3	3	4	28	30	12	16	12	11	7	0	0
22	RK	28	2	S	1	7	4	3	6	6	6	21	27	13	8	9	10	8	0	0
23	GS	28	2	S	2	5	8	7	5	4	3	19	24	11	8	11	9	4	0	0
24	MA	27	2	S	1	8	7	5	6	3	3	25	31	16	9	12	11	7	0	0
25	AM	23	2	S	1	11	5	3	7	2	4	20	27	13	7	10	10	7	0	0
26	MMH	26	2	S	2	7	6	4	5	4	5	22	26	13	9	9	12	5	0	0
27	AC	25	2	S	2	9	3	5	6	2	7	26	29	15	11	12	10	7	2	2
28	DC	23	2	S	2	7	9	5	4	4	3	29	31	16	13	12	11	8	0	0
29	AB	22	2	S	2	7	11	3	3	6	2	32	35	14	18	12	12	11	0	0
30	RRC	30	2	S	2	5	7	7	5	4	4	24	27	15	9	10	9	8	0	0
31	TA	30	2	S	2	3	10	9	5	4	1	21	25	12	9	9	11	5	0	0
32	KA	28	2	S	1	10	6	4	3	2	7	27	29	15	12	11	12	6	0	0
33	MKS	27	2	S	2	8	4	3	7	5	5	24	27	16	8	8	12	7	1	1
34	SA	27	2	M	2	6	9	7	3	3	4	22	24	9	13	8	9	7	0	0
35	UV	26	2	S	1	9	5	7	6	0	5	26	29	15	11	12	10	7	0	0
36	AK	26	2	S	2	9	6	5	6	2	4	23	26	13	10	11	9	6	0	0
37	ST	26	2	M	2	7	10	5	3	4	3	20	18	11	9	10	5	3	0	0
38	MKS	28	2	S	2	5	7	7	5	4	4	21	25	16	9	9	9	7	0	0
39	M	32	2	S	2	9	4	6	8	1	4	18	20	13	5	11	6	3	0	0
40	PD	27	2	S	2	11	8	2	5	3	3	29	31	16	13	11	11	9	3	3
41	MA	27	2	S	2	8	6	5	7	3	3	31	29	17	14	10	11	8	0	0
42	HA	26	2	S	2	7	5	6	5	3	6	22	28	11	11	9	12	7	0	0
43	AS	29	2	S	2	7	9	3	5	6	1	25	26	16	9	11	9	6	0	0
44	VG	22	2	S	2	5	8	7	6	4	2	28	31	15	13	12	10	9	0	0
45	P	24	2	M	2	9	5	3	6	4	5	21	29	12	9	12	9	8	0	0
46	V	34	2	M	1	10	3	5	8	2	5	30	22	16	14	8	8	6	0	0
47	SK	33	2	M	2	11	7	3	6	2	3	28	30	15	13	12	10	8	0	0
48	GB	31	2	S	2	6	9	6	5	4	2	23	27	15	8	10	7	6	0	0
49	JJ	28	2	S	2	7	5	4	9	5	7	27	30	12	15	11	10	9	1	0
50	RD	21	2	S	2	9	5	5	7	2	4	22	28	13	9	12	11	5	0	0

S.NO	NAME	MOTHER	FATHER	FAMILY UNIT	SACKS-SA	FEMALE	OPP SEX	SACS-IR	FRIENDS	SUPERVISED	COLLEAGUES	SUPERIORS	FEAR	SACKS-SC	GUILT	ABILITY	PAST	FUTURE	GOAL	MQ-ACH	MQ-AFF	MQ-POW
1	SYJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	2	2
2	DS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	1	2
3	JK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	2
4	AV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	6	1
5	AV	0	0	0	0	0	0	2	0	0	0	1	1	0	0	0	0	0	0	7	3	1
6	A	0	0	0	0	0	0	4	2	0	0	2	0	0	0	0	0	0	0	5	1	4
7	SJD	0	0	0	0	0	0	3	1	0	2	0	0	0	0	0	0	0	0	6	3	2
8	SG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	2	1
9	AS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9	2	0
10	AS	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1	0	0	7	3	1
11	SSS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	2
12	DB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	6	0
13	KR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	2	1
14	RK	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	6	3	2
15	NK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	2	2
16	SD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9	0	2
17	SSS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	2
18	PK	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	4	1
19	TS	0	0	0	0	0	0	1	0	0	0	1	0	1	0	0	0	1	0	7	3	1
20	AS	0	0	0	0	0	0	3	0	2	0	0	1	0	0	0	0	0	0	8	2	1
21	I	0	0	0	0	0	0	0	0	0	0	0	0	2	0	1	0	1	0	5	4	2
22	RK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	5	2
23	GS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	2
24	MA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	2	2
25	AM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	3	1
26	MMH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9	1	1
27	AC	0	1	1	0	0	0	2	1	0	1	0	0	0	0	0	0	0	0	6	4	1
28	DC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	3	1
29	AB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	2	4
30	RRC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	2	2
31	TA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	1	3
32	KA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	4	2
33	MKS	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	3	3
34	SA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	3	1
35	UV	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	2	2
36	AK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	2
37	ST	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	4	1
38	MKS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	2	3
39	M	0	0	0	0	0	0	2	0	0	0	1	1	1	0	1	0	0	0	7	3	1
40	PD	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9	1	1
41	MA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	2
42	HA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5	1
43	AS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	2	1
44	VG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	1	2
45	P	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	4	2
46	V	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	2
47	SK	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	4	1
48	GB	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	6	3	2
49	JJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	2	2
50	RD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	3	1

Baba Farid University
of Health Sciences
Sadiq Road
Faridkot-151 203 (Pb). INDIA.
Phone : 01639-256232,256236
Tele/Fax : 01639-256235
Email – Examination@bfuhs.ac.in

No. BFUHS/2K21p-TH/ 1626

Date 15/2/21

The Principal,
DMC,Ludhiana.

Subject: **Approval of Plan of Thesis.**

This is to inform you that the Faculty of Medical Sciences in its meeting held on 22.01.2021 has approved the plan of thesis of Dr. Sussana Yarusha John, a student of your college for **M.Phil. (Clinical Psychology)** along with the names of Supervisor/Co-Supervisor as under:-

Topic Plan of Thesis

To study the parental relationship, attributional bias, motivational needs and types of conflicts in young adults with and without substance use disorder

Supervisor

Dr. Bholeshwar Prasad Mishra
Prof. & Head,
Dept. of Clinical Psychology,

Co-Supervisor

Dr. Rupesh Chaudhary
Prof.,
Dept. of Psychiatry,
DMCH, Ludhiana

Ms. Palak Upadhyay
Asst. Prof.,
Dept. of Clinical Psychology,

The student has to submit the three copies of thesis (along with PDF format) , to the Controller of Examinations, BFUHS, Faridkot, at least six months before the commencement of theory examination, if he/she is otherwise eligible to take the examination. He /She must directed to attach a photocopy of this letter with the forwarding letter while submitting thesis to the University along with the letter of approval of University for change of supervisor/Co-Supervisor, change of topic,(if any).

Dr. S P Singh MS(Oph)
Controller of Examinations

Note :

3. *If any discrepancy found regarding topic of thesis or Supervisor/Co-Supervisor, inform undersigned within one month after issue of this letter.*

TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER

THESIS PROPOSAL

FOR APPROVAL OF SUBJECT OF THESIS TO BE SUBMITTED

IN PARTIAL FULFILMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

M. PHIL

IN

CLINICAL PSYCHOLOGY

OF THE

BABA FARID UNIVERSITY OF HEALTH SCIENCES

FARIDKOT

JUNE, 2020

SUSSANA YARUSHA JOHN

DEPARTMENT OF CLINICAL PSYCHOLOGY
DAYANAND MEDICAL COLLEGE AND HOSPITAL
LUDHIANA

ABSTRACT OF PLAN OF THESIS

Title	TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER
For the degree of	M.Phil Clinical Psychology
Name of the candidate	SussanaYarusha John
Supervisor	Dr. Bholeshwar Prasad Mishra, Professor & Head, Department of Clinical Psychology, DMCH, Ludhiana
Co-supervisor	Dr. Rupesh Chaudhary, Professor, Department of Psychiatry, DMCH, Ludhiana Ms. Palak Upadhyay, Assistant Professor, Department of Clinical Psychology, DMCH, Ludhiana
Institution	Dayanand Medical College & Hospital, Ludhiana
University	Baba Farid University of Health Sciences, Faridkot

Introduction: Substance abuse is a common problem among young adults and it has devastating affects both on the individual and the family members. These individuals have a lot of conflicts with the family, their own self and in interpersonal relationships. They also might have attributional biases to which they credit their problem behavior and motivational needs that could be addressed in making a holistic family-based intervention.

Aim of Study: 1)To compare the parental relationship of young adults with and without substance use disorder(SUD). 2)To compare the internal, personal and situation attributional bias in young adults with and without SUD. 3)To compare the motivational needs of young adults with and without SUD. 4)To compare the types of conflicts in young adults with and without SUD.

Materials & methods: The study will be conducted on patients(N=50) of Substance Use Disorder and healthy control group (N=50) admitted in psychiatry ward and visiting De-addiction OPD at DMC&H and psychological evaluation will be done using The Parent Adult-Child Relationship Questionnaire (PACQ), Internal, Personal and Situational Attribute Questionnaire (IPSAQ), Motivational Questionnaire and Sacks Sentence Completion Test (SSCT).

Clinical Significance: The study will contribute to family-based interventions addressing the different conflicts, attributional biases and motivational needs and how these problems could be solved.

Keywords: Substance use disorder, Types of Conflicts, Parental Relationship, Motivational Needs, Attributional Bias, Drug addicts, Young Adults.

(Signature)	(Signature)	(Signature)	(Signature)	(Signature)
Candidate	Co-supervisor	Co-supervisor	Supervisor	Principal

CERTIFICATE OF FACILITIES AVAILABLE

This is to certify that the facilities for work on the subject of thesis titled **"TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER"** exist in the Department of Psychiatry, DMC&H, Ludhiana and will be provided to the candidate. We will see that the data being included in the thesis is genuine and is collected by the candidate himself/herself under our supervision and guidance.

Supervisor

Dr.Bholeshwar Prasad Mishra
Professor & Head
Department of Clinical Psychology
DMCH, Ludhiana

Co-Supervisors

Dr. Rupesh Chaudhary
Professor
Department of Psychiatry
DMCH, Ludhiana

Ms.Palak Upadhyay
Assistant Professor
Department of Clinical Psychology
DMCH, Ludhiana

Head of the Department

Dr. Bholeshwar Prasad Mishra
Professor & Head
Department of Clinical Psychology
DMCH, Ludhiana

Place: Ludhiana

Date: 30.06.2020

DR. B.P. MISHRA
Professor & Head
Dept. of Clinical Psychology
DMCH, Ludhiana

APPROVAL PROFORMA
BY RESEARCH & ETHICAL COMMITTEE
DAYANAND MEDICAL COLLEGE & HOSPITAL, LUDHIANA

Name of candidate	SUSSANA YARUSHA JOHN
Department	Clinical Psychology
Topic of Thesis	TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS HAVING SUBSTANCE USE DISORDER - A COMPARATIVE STUDY
Likely date of appearing in PG examination	JUNE 2021
Date of enrollment	23.08.2019
Name of Head of Department	Dr.Bholeshwar Prasad Mishra
1) Supervisor **2) Co-Supervisor(s)**	Dr. Bholeshwar Prasad Mishra Dr. Rupesh Chaudhary Ms. Palak Upadhyay
Signature of Members of Research Committee with Stamp	**Signature of Members of Ethics Committee with Stamp**
Dr. Jaspal Singh (Professor & Head, Surgery)	Mr. A K Jindal (Member, Ethics Committee)
Dr. Dinesh Gupta (Professor & Head, Medicine)	Dr. Anu Sharma (Professor, Anatomy)
Dr. Sandeep Kaushal (Assistant Dean Academics)	Dr. Deepinder K Chhina (Professor & Head, Microbiology)
Dr. Rajoo Singh Chhina (Dean Academics)	Dr. Neena Sood (Professor & Head, Pathology)
Dr. Gurpreet S Wander (Vice Principal)	Dr. Gurpreet S Wander (Vice Principal)
	Dr. Gagandeep Singh (Secretary, Ethics Committee Professor & Head, Neurology)

Approved: Yes / No

Dr. Sandeep Puri
Chairperson
Research Committee

Approved: Yes / ~~No~~

Prof. Arvind Malhotra
Chairperson
Ethics Committee

BABA FARID UNIVERSITY OF HEALTH SCIENCES, FARIDKOT

PROFORMA FOR REGISTRATION OF SUBJECT FOR DISSERTATION

1	NAME OF THE CANDIDATE AND ADDRESS	SUSSANA YARUSHA JOHN ST. ANDREWS COLLEGE CAMPUS, CIVIL LINES, GORAKHPUR 273001
2	NAME OF THE INSTITUTE	DAYANAND MEDICAL COLLEGE AND HOSPITAL, LUDHIANA
3	COURSE OF STUDY AND SUBJECT	M PHIL CLINICAL PSYCHOLOGY
4	DATE OF ADMISSION OF COURSE	23.08.2019
5	TITLE OF THE TOPIC	TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER

6. BRIEF RESUME OF THE INTENDED WORK

6.1 NEED FOR THE STUDY

Substance abuse refers to excessive use of a drug in a way that is detrimental to self, society, or both. This definition includes both physical dependence and psychologic dependence. Physical dependence caused by prolonged use of a drug refers to an altered physiologic state in which withdrawal symptoms develop when the drug is discontinued. Psychologic dependence refers to a state of intense need to continue taking a drug in the absence of physical dependence.[1] Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.(WHO)

A Study was conducted on prevalence patterns and familial aspects of substance use among adolescents in North India and it was found that prevalence of substance use was seen in 52.7% students belonging to age group 19 to 21 years.[2] It is estimated that, in India, by the time most boys reach ninth grade, 50% of them have tried at least one of the substance of the abuse nature.[3] Influence of peers and close contacts who use substances are usually responsible for initiating their use in others.[1] Illicit drug use—which includes the abuse of illegal drugs and/or the misuse of prescription medications or household substances—is something many adolescents engage in occasionally, and a few do regularly. By the 12th grade, about half of adolescents have misused an illicit drug at least once. The most commonly used drug is marijuana, but adolescents can find many harmful substances in the home, such as prescription medications, glues, and aerosols.[4]

People with strong achievement need like situations in which they can take personal responsibility for solving problems. They tend to take moderate risks and desire feedback concerning their performances.

The need for affiliation reflects a desire to interact socially with people. Such an individual is concerned about the quality of interpersonal relationships.

The individual with high need for power concentrates on obtaining and exercising power and authority. He is concerned with influencing others and winning arguments.[7] Studies have shown that there is prevalence of drug abuse in adolescents and young adults but there are few studies assessing the types of conflicts in these users, attributional bias, motivational needs. Further research is needed into the area of finding out the types of conflicts including parental conflicts, attributional bias and motivational needs in order to plan with the family based interventions.

6.2 REVIEW OF LITERATURE

A study on Coping via substance use, internal attribution bias, and their depressive interplay, investigated whether internal attribution bias coupled with a tendency to use drugs and/or alcohol to cope predicts increases in depression and daily-levels of general negative affectivity, sadness, and hostility. Results showed that substance use to cope predicted increases in depression among individuals with high-level internal attribution bias. Further, coping via substance use moderated the relationship between internal attribution bias and daily-level sadness, such that sadness was highest among individuals with a high internal attribution bias coupled with greater levels of coping via substance use.[8]

In a research investigating self-relevant attributions and coping with drugs or alcohol remains limited; however, there is evidence of a positive association between internal attributional style and illicit drug use.[9]

In a Prospective Study of Familial Conflict, Psychological Stress, and the Development of Substance Use Disorders in Adolescence shows that Familial conflict was significantly associated with the risk of substance use disorders during adolescence, and 30% of this effect was due to higher levels of externalizing problems. Exposure to familial conflict early in life increases the risk of substance use disorders during late adolescence and emerging adulthood.[10]

A child's family environment has been recognized as one of the most significant influences on a variety of subsequent behavioral outcomes, including substance use problems in adolescence (Bray et al., 2001; Johnson and Pandina, 1991; Nation and Heflinger, 2006).

In one of the largest scientific research studies examining the relationship between adversity in childhood and behavioral outcomes later in life, the Adverse Childhood Experiences (ACE) study investigated the effects of abuse, neglect, and household dysfunction on substance use problems in adolescence and adulthood. Using retrospective reports, findings indicated that exposure to such adverse family environments was significantly associated with alcohol use

initiation in early adolescence (prior to age 14) and in mid-adolescence (between ages 15 and 17) (Dube et al., 2006), alcohol abuse in adulthood (Dube et al., 2002) and illicit drug use problems in adolescence (Dube et al., 2003). These studies also found a graded relationship between adverse childhood experiences and substance use problems, in that a higher number of adverse childhood experiences was associated with an increasing risk for alcohol and illicit drug problems.

Family environments with high levels of adversity, including violence, stress, parental drug use, ineffective communication and discipline, and poor sibling relationships, have been linked to adolescent drug use.[11,12]

In a study on Adverse childhood experiences and personal alcohol abuse as an adult, A questionnaire about childhood abuse, parental alcoholism and family dysfunction while growing up was completed by adult HMO members in order to retrospectively assess the independent relationship of eight ACEs to the risk of adult alcohol abuse. Each of the eight individual ACEs was associated with a higher risk alcohol abuse as an adult. Compared to persons with no ACEs, the risk of heavy drinking, self-reported alcoholism, and marrying an alcoholic were increased twofold to fourfold by the presence of multiple ACEs, regardless of parental alcoholism. Prevention of ACEs and treatment of persons affected by them may reduce the occurrence of adult alcohol problems.[13,14]

In a study on Family risk factors for alcohol-related consequences and poor adjustment in fraternity and sorority members: exploring the role of parent-child conflict, parent-child conflict at baseline significantly predicted alcohol-related consequences 1 year later for all students. Father-child conflict was a significantly better predictor for male students. Parent histories of problem drinking did not account for this relationship.[15]

In a study on the role of attributions in abstinence, lapse, and relapse following substance abuse treatment showed that abstainers made more internal, stable, and global attributions regarding their

abstinence. Abstainers' attributions for their success in remaining abstinent tended to be similar to the attributions made by relapsers for their failure to remain abstinent.[16]

In one of the studies testing the social stress model of substance abuse among a sample of urban adolescents, Rhodes and Jason (1990) demonstrated that poor family environments (i.e., poor parental relationships, a high degree of family problems) were significantly associated with a higher level of drug use.[17]

6.3 AIMS AND OBJECTIVES OF THE STUDY

1. To compare the parental relationship of young adults with and without SUD.
2. To compare the internal, personal and situation attributional bias in young adults with and without SUD.
3. To compare the motivational needs of young adults with and without SUD.
4. To compare the types of conflicts in young adults with and without SUD.

7. MATERIALS AND METHODS

7.1 SOURCE OF DATA

Study will be conducted on 50 SUD patients (25 having alcohol use disorder and 25 having opioid use disorder) and 50 healthy individuals as control group, admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College and Hospital.

7.2 METHOD OF COLLECTION OF DATA

SAMPLE COLLECTION- The study will be conducted on of 50 SUD patients (25 patients with alcohol use disorder and 25 patients with opioid use disorder) and 50 healthy individuals as control group from 18 to 35 years of age, admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College and Hospital.

INCLUSION CRITERIA (experimental group)

- Patients having a diagnosis of any substance use disorder according to DSM 5.
- Age group between 18 to 35 years.
- Patients having SUD, admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College and Hospital.
- Patients willing to give informed consent.

EXCLUSION CRITERIA (experimental group)

- Patients with any major psychotic illness, developmental disability and intellectual disability.
- Patients not willing to give informed consent.

INCLUSION CRITERIA (control group)

- Healthy control group not having any major psychiatric illness.
- Individuals not having the diagnosis of any SUD.
- Age group between 18 to 35 years.
- Patients willing to give informed consent.

EXCLUSION CRITERIA (control group)

- Individual having any psychiatric illness, developmental disability and intellectual disability.

- Patients not willing to give informed consent.

METHODOLOGY

The study will be conducted on 50 SUD patients (25 patients with alcohol use disorder and 25 patients with opioid use disorder) and 50 individuals without SUD (control group) from 18 to 35 years of age, admitted in psychiatry ward and visiting De-addiction OPD at Dayanand Medical College, Ludhiana. Socio Demographic Proforma will be filled containing the basic information of the subject and they will be evaluated for parental relationship using The Parent Adult-Child Relationship Questionnaire (PACQ), attributional bias using Internal, Personal and Situational Attribute Questionnaire (IPSAQ), motivational needs using Motivational Questionnaire and types of conflicts by administering Sacks Sentence Completion Test (SSCT).

TOOLS:

1. Socio-Demographic Proforma
2. The Parent Adult-Child Relationship Questionnaire (PACQ)
3. Internal, Personal and Situational Attribute Questionnaire (IPSAQ)
4. Motivational Questionnaire
5. Sacks Sentence Completion Test (SSCT)

1. **The Parent Adult-Child Relationship Questionnaire (PACQ) (Peisah, C., Brodaty, H., Luscombe, G., Kruk, J., & Anstey, K.)** It is a short 26-item questionnaire that measures the familial relationship between parent and the adult child, from the adult child's point of view. It is divided into two subscales assessing 'relationship with mother' (PACQM) comprising 13 items, and 'relationship with father' (13 items). The instrument can be self-administered and is applicable to both sexes.
2. **Internal, Personal and Situational Attribute Questionnaire (IPSAQ) (Peter Kinderman and Prof. Richard P. Bentall).** It is a 32-item questionnaire that measures three types of attributes that are: internal attribution; external-personal attribution and external-situational attribution.

3. **Motivational Questionnaire (Brown, J, Culp, III, K., Doyle, J, Kelley, D., Ragland, K., Tarry, P, Turley, J and Turner, S).** It is a 11-item short questionnaire which helps in determining if the individual is motivated by achievement, power or affiliation needs.
4. **Sacks Sentence Completion Test (SSCT) (Sacks, J.M. & Levy, S. 1950):** The tool is a 60-item test that asks respondents to complete 60 questions with the first thing that comes to mind across four areas: Family, Sex, Interpersonal Relationships and Self concept. It is helpful in finding out the conflicts in the above four areas.

OUTCOME

In this study it will be observed that there will be poor parental relationship, significant types of conflicts in areas that including conflict with self concept, sex, interpersonal and family. There are very few studies on attributional bias in SUD patients i.e., to what do they attribute their problem behavior to whether internal, situational or personal attribution. There are various studies on motivational interviewing but motivational needs of these patients have not been studied. So, we could address the attributional biases, motivational needs and types of conflicts of such individual and this could contribute to holistic family-based intervention.

STATISTICAL ANALYSIS

Data will be described in terms of range; mean ±standard deviation (± SD), median, frequencies (number of cases) and relative frequencies (percentages) as appropriate. Comparison of quantitative variables between the groups will be done using Student t-test and Mann Whitney U test for independent samples for parametric and non-parametric data respectively. Comparison of quantitative variables within the groups will be done using paired t-test. For comparing categorical data, Chi square ($\chi 2$) test will be performed and exact test will be used when the expected frequency is less than 5. A probability value (p value) less than 0.05 will be considered statistically significant. All statistical calculations will be done using SPSS (Statistical Package

for the Social Science) SPSS 21 version statistical program for Microsoft Windows.

7.3 DOES THE STUDY REQUIRE ANY INVESTIGATIONS OR INTERVENTIONS TO BE CONDUCTED ON PATIENTS OR OTHER HUMANS OR ANIMALS? IF SO, PLEASE DESCRIBE BRIEFLY.

NO

HAS ETHICAL CLEARENCE BEEN OBTAINED FROM YOUR INSTITUTION IN CASE OF 7.3?

Yes, Attached herewith

8. LIST OF REFERENCES

1. Griffin JB. Substance abuse. In Clinical Methods: The History, Physical, and Laboratory Examinations. 3rd edition 1990. Butterworths.
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ਮਰੀਜ਼ ਰਜ਼ਾਮੰਦੀ ਫ਼ਾਰਮ

ਮਿਤੀ_____

ਮੈ_____ਪਤਨੀ/ਪੁੱਤਰ/ਪੁੱਤਰੀ_____

ਵਾਸੀ _____ _____

"TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER" ਤੇ ਚਲ ਰਹੀ ਖੋਜ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਰਜ਼ਾਮੰਦ ਹਾਂ। ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਲਈ ਮੈ ਆਪਣੀ ਮਰਜ਼ੀ ਨਾਲ ਤਿਆਰ ਹਾਂ। ਮੈ ਇਹ ਦਸਣਾ ਚਾਹੁੰਦਾ ਹਾਂ/ ਚਾਹੁੰਦੀ ਹਾਂ ਕੇ ਇਹ ਰਜ਼ਾਮੰਦੀ ਦੇਣ ਵਾਸਤੇ ਮੈਨੂ ਕਿਸੇ ਵੀ ਤਰਾਂ ਦਾ ਲੋਭ-ਲਾਲਚ ਨਹੀ ਦਿੱਤਾ ਗਿਆ ਅਤੇ ਨਾ ਹੀ ਕੋਈ ਦਬਾ ਪਾਇਆ ਗਿਆ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਦਾ ਮਨੋਰਥ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਭਰੋਸਾ ਦਵਾਇਆ ਗਿਆ ਹੈ ਕੇ ਇਹ ਖੋਜ ਵਿਗਿਆਨ ਅਤੇ ਮਾਨਵਤਾ ਦੀ ਭਲਾਈ ਲਈ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਵਿਚ ਹੋਣ ਵਾਲੇ ਖਤਰੇ ਬਾਰੇ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ ਅਤੇ ਮੈਨੂ ਇਹ ਯਕੀਨ ਹੈ ਕੇ ਇਹ ਖਤਰਾ ਬਹੁਤ ਮਾਮੂਲੀ ਹੈ। ਮੈਨੂ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਦਾ ਢੰਗ – ਤਰੀਕਾ ਸਮਝਾ ਦਿੱਤਾ ਗਿਆ ਹੈ।

ਮੈ ਇਸ ਖੋਜ ਕੰਮ ਵਿਚ ਹਿੱਸਾ ਲੈਣ ਬਾਰੇ ਆਪਣੀ ਰਜ਼ਾਮੰਦੀ ਕਿਸੇ ਵੀ ਸਮੇ ਵਾਪਸ ਲੈ ਸਕਦਾ ਹਾਂ/ ਸਕਦੀ ਹਾਂ ਅਤੇ ਮੇਰੀ ਰਜ਼ਾਮੰਦੀ ਵਾਪਸ ਲੈਣ ਦਾ ਮੇਰੇ ਇਲਾਜ ਤੇ ਕੋਈ ਅਸਰ ਨਹੀ ਹੋਵੇਗਾ।

_____ _____

ਗਵਾਹ ਦੇ ਹਸਤਾਖਰ ਮਰੀਜ਼ ਦੇ ਹਸਤਾਖਰ

ਮਿਤੀ_____ ਮਿਤੀ_____

ਪਤਾ _____ ਪਤਾ _____

_____

ਨਿਰੀਖਕ ਦੇ ਹਸਤਾਖਰ

_____

ਸਿਖਿਆਰਥੀ ਦੇ ਹਸਤਾਖਰ

मरीज अनुमति फार्म

तिथि _____

मैं _____ पत्नीp/पुत्र/पुत्री _____

निवासी _____

इस शोधकार्य **"TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER"** में भाग लेने के लिए सहमत हूँ। मैं इस शोधकार्य में भाग लेने के लिए अपनी स्वेच्छा से तैयार हूँ। मैं पुष्टिए करता/करती हूँ की यह स्वीकृति देने के लिए मुझे कोई आर्थिक प्रलोभन नहीं दिया गया और न ही दबाव डाला गया है। मुझे इस शोधकार्य का उद्देश्य स्पष्टा कर दिया गया है और मुझे यह विश्वाीस है की यह विज्ञान और मानवता के लाभ के लिए है। मुझे इस शोधकार्य में होने वाले जोखिम के बारे में समझा दिया गया है और मेरी समझ में यह जोखिम बहुत मामुली है।

मैं इस शोधकार्य में भाग लेने के सम्बन्ध में किसी भी समय अपनी अस्वीकृति व्यक्तम कर सकता/सकती हूँ और मेरे अस्वीकृति व्यक्तक करने का मेरे इलाज पर कोई प्रभाव नहीं पड़ेगा।

_____ _____

गवाह के हस्ताक्षर रोगी के हस्ताक्षर /अंगूठे का निशान

नाम: नाम:

_____

अन्वेषक के हस्ताक्षर

_____

विद्यार्थी के हस्ताक्षर

INFORMED PATIENT CONSENT

Date: _____

I.....D/o, W/o, S/o.....
.....am willing to participate in the study **"TO STUDY THE PARENTAL RELATIONSHIP, ATTRIBUTIONAL BIAS, MOTIVATIONAL NEEDS AND TYPES OF CONFLICTS IN YOUNG ADULTS WITH AND WITHOUT SUBSTANCE USE DISORDER"** The procedure with its complications has been explained to me in local vernacular language. I have fully understood that no special tests and extra expenditure in any form, merely for the purpose of thesis is being carried out. I am free to opt out the study any time without assigning any reason.

.....
Signature of the Witness

Name:

.....
Signature of the patient

Signature of Candidate

Signature of Supervisor

SOCIO-DEMOGRAPHIC PROFORMA

S.NO:- **Date:**

1. NAME:

2. AGE: a) 18-23 b) 24-29 c) 30-35

3. SEX:- Male/ Female

4. MRD.NO:-

5. Education-

a) Illiterate b) Upto Matric

c) 10th d) 12th e) Graduate f) Post graduate

6. Occupation-

a) Farmer/Clerical/Shopkeeper b) Semi-skilled/skilled worker

c) Unemployed d) Other

e) Professional f) Student

7. Marital Status- Single/ Married/ Widowed/Divorced/ Separated

8. Address- a) Urban b) Rural

9. Contact no.-

10. Family Type- a) Nuclear b) Joint

11. Education of the Head of family

1. Professional degree
2. Graduate or post graduate

3. Intermediate or post high school diploma
4. High school certificate
5. Middle school certificate
6. Primary school certificate
7. Illiterate

12. Occupation of the head of family

1. Professional
2. Semi- professional
3. Clerical, shop owner/farm
4. Semi-skilled worker
5. Unskilled worker
6. Unemployed

13. Monthly income of the family

1. >52,734
2. 26,335-52,733
3. 19,759-26,354
4. 13,161- 19,758
5. 7,887-13,160
6. 2,641-7,886
7. <2,640

14. Socio economic status

1. Upper
2. Upper middle
3. Lower middle
4. Upper lower
5. Lower

15. SCALES:

1. INTERNAL, PERSONAL, AND SITUATIONAL ATTRIBUTION QUESTIONNAIRE

A. An internal attribution Positive:
B. An external, personal, attribution
C. An external, situational, attribution Negative:

2. THE PARENT ADULT CHILD RELATIONSHIP QUESTIONNAIRE

Relationship with Mother (PACQM)

Regard Scale- Score:
Responsibility Scale- Score:

Relationship with Father (PACQF)

Regard Scale- Score:
Responsibility Scale- Score:
Control scale Italic- Score:

3. SACK'S SENTENCE COMPLETION TEST (SSCT)

Family area- Score:
Sex area- Score:
Interpersonal Relationship- Score:
Self Concept- Score:

4. MOTIVATIONAL QUESTIONNAIRE

TOTAL: _____ Achievement
_____ Affiliation
_____ Power / Control

DRUG USE: a) alcohol b) opioid c) control

The Parent Adult-Child Relationship Questionnaire

This form contains a number of statements about relationships between adults and their parents. Please read each statement carefully, and decide how well it describes your relationship with your mother and your father as it has been over the last year.

Please circle the most appropriate response of the four possible responses.

Very true

Tick if you feel that the statement describes your relationship with your parent accurately.

Moderately true

Tick if you feel that the statement describes your relationship with your parent for the most part.

Somewhat true

Tick if you feel that the statement describes your relationship with your parent to a small extent.

Not true at all

Tick if you feel that the statement does not describe your relationship with your parent at all.

Relationship with Mother (PACQM)

Very true (3/Ⅲ)
Moderately true (2/Ⅱ)
Somewhat true (1/Ⅰ)
Not true at all (0/0)

1. I look forward to seeing my mother (3) (2) (1) (0)
2. I feel responsible for my mother's happiness. (Ⅲ) (Ⅱ) (Ⅰ) (0)
3. I feel that I should take care of my mother because she has suffered so much in her life. (Ⅲ) (Ⅱ) (Ⅰ) (0)
4. My mother is my best friend. (3) (2) (1) (0)
5. My mother's difficulty in making decisions has been a burden on me. (Ⅲ) (Ⅱ) (Ⅰ) (0)
6. My mother shows her appreciation of me. (3) (2) (Ⅰ) (0)
7. I am the only one my mother can rely on. (Ⅲ) (Ⅱ) (Ⅰ) (0)
8. My mother thinks I am good in a crisis so she calls on

me all the time. (Ⅲ) (Ⅱ) (Ⅰ) (0)
9. I respect my mother's opinion. (3) (2) (1) (0)
10. I feel that I have to protect my mother. (Ⅲ) (Ⅱ) (Ⅰ) (0)
11. My mother relies on me too much. (Ⅲ) (Ⅱ) (Ⅰ) (0)
12. I am glad to be able to repay my mother for all the love and care she gave me as a child. (3) (2) (1) (0)
13. I feel like I parent my mother. (Ⅲ) (Ⅱ) (Ⅰ) (0)

Relationship with Father (PACQF)

Very true (3)/(Ⅲ)
Moderately true (2)/(Ⅱ)
Somewhat true (1)/(Ⅰ)
Not true at all (0)/(0)

1. If I don' t do things my father's way he will nag me. (3) (2) (1) (0)
2. I respect my father's opinion. (3) (2) (1) (0)
3. Something will happen to my father if I don' t take care of him. (Ⅲ) (Ⅱ) (Ⅰ) (0)
4. I feel that my father tries to manipulate me. (3) (2) (1) (0)
5. I look forward to seeing my father. (3) (2) (1) (0)
6. I feel responsible for my father's happiness. (Ⅲ) (Ⅱ) (Ⅰ) (0)
7. My father tries to dominate me. (3) (2) (1) (0)
8. I feel that my father makes too many demands on me. (3) (2) (1) (0)
9. I know I can rely on my father to help me if I need him. (3) (2) (1) (0)
10. If I don't see my father for a week I feel guilty. (Ⅲ) (Ⅱ) (Ⅰ) (0)
11. I don't discuss much with my father because I'm afraid of being criticized. (3) (2) (1) (0)
12. I don't mind putting myself out for my father. (3) (2) (1) (0)
13. My father thinks I'm good in a crisis so he calls on me all the time. (Ⅲ) (Ⅱ) (Ⅰ) (0)

I.P.S.A.Q.

Name: _____ Sex:

Age: _____ Occupation:

Date Completed:

INSTRUCTIONS

Please read the statements on the following pages. For each statement please try to vividly imagine that event happening to you. Then try to decide what was the main cause of the event described in each statement. Please write the cause you have thought of in the space provided. Then tick the appropriate letter (a,b or c) according to whether the cause is :

a) Something about you

b) Something about another person (or a group of people)

c) Something about the situation (circumstances or chance)

It might be quite difficult to decide which of these options is exactly right. In this case, please pick **one option**, the option which **best** represents your opinion. Please pick **only one** letter in each case.

Thank you for your time and co-operation.

1. A friend gave you a lift home.

What caused your friend to give you a lift home?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

2. A friend talked about you behind your back.

What caused your friend to talk about you behind your back?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

3. A friend said that he(she) has no respect for you.

What caused your friend to say that he(she) has no respect for you ?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

4. A friend helped you with the gardening.

What caused your friend to help you with the gardening?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

5. A friend thinks you are trustworthy.

What caused your friend to think you are trustworthy?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

6. A friend refused to talk to you.

What caused your friend to refuse to talk to you?
(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

7. A friend thinks you are interesting.

What caused your friend to think you are interesting?
(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

8. A friend sent you a postcard.

What caused your friend to send you a postcard?
(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

9. A friend thinks you are unfriendly.

What caused your friend to think that you are unfriendly?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

10. A friend made an insulting remark to you.

What caused your friend to insult you?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

11. A friend bought you a present.

What caused your friend to buy you a present .

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

12. A friend picked a fight with you.

What caused your friend to fight with you?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

13. A friend thinks you are dishonest.

What caused your friend to think you are dishonest?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you?

b. Something about the other person or other people?

c. Something about the situation (circumstances or chance)?

14. A friend spent some time talking to you.

What caused your friend to spend time talking with you?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?

b. Something about the other person or other people ?

c. Something about the situation (circumstances or chance) ?

15. A friend thinks you are clever.

What caused your friend to think you are clever?

(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

16. A friend refused to help you with a job.

What caused your friend to refuse to help you with the job?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

17. A friend thinks you are sensible.

What caused your friend to think that you were sensible?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

18. A friend thinks you are unfair.

What caused your friend to think that you are unfair?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

19. A friend said that he(she) dislikes you.

What caused your friend to say that he(she) dislikes you?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

20. A friend rang to enquire about you.

What caused your friend to ring to enquire about you?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

21. A friend ignored you

What caused your friend to ignore you?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

22. A friend said that she(he) admires you.

What caused your friend to say that she(he) admired you?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

23. A friend said that he(she) finds you boring.

What caused your friend to say that he(she) finds you boring?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

24. A friend said that she(he) resents you.

What caused your friend to say that she(he) resents you?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

25. A friend visited you for a friendly chat.

What caused your friend to visit you for a chat?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

26. A friend believes that you are honest

What caused your friend to believe that you are honest?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

27. A friend betrayed the trust you had in her.

What caused your friend to betray your trust?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

28. A friend ordered you to leave.

What caused your friend to order you to leave?
(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

29. A friend said that she(he) respects you.

What caused your friend to say that she(he) respects you?
(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

30. A friend thinks you are stupid.

What caused your friend to think that you are stupid?
(Please write down the one major cause)

. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

31. A friend said that he(she) liked you.

What caused your friend to say that he(she) liked you?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

32. A neighbor invited you in for a drink.

What caused your friend to invite you in for a drink?
(Please write down the one major cause)

. . . . . .
. . . . . .

Is this :

a. Something about you ?
b. Something about the other person or other people ?
c. Something about the situation (circumstances or chance) ?

MOTIVATIONAL QUESTIONNAIRE

The following assessment will determine if the individual is motivated by achievement, power or affiliation. The participant should choose the statement in each set that best describes him. The questionnaire is followed by an answer key to determine which best describes how the individual is motivated.

___a. When doing a job, I need feedback.
___ b. I prefer to work alone and be my own boss.
___ c. I am uncomfortable when forced to work alone.

___ a. I go out of my way to make friends with new people.
___ b. I enjoy a good argument.
___ c. After starting a task, I am uncomfortable until it is finished.

___ a. Status symbols are important to me.
___ b. I am always getting involved with group projects.
___ c. I work better when there is a deadline.

___ a. I work best when there is some challenge involved.
___ b. I would rather give orders than take them.
___ c. I am sensitive to others, especially when they are angry.

___a. I am eager to be my own boss.
___ b. I accept responsibility eagerly.
___ c. I get personally involved with my superiors.

___ a. I include others in what I am doing.
___ b. I prefer to be in charge of events.
___ c. When given responsibility, I set measurable standards of high performance.

___ a. I am concerned about my reputation or position.
___ b. I desire to out-perform others.
___ c. I am concerned about being liked and accepted.

___ a. I enjoy and seek warm, friendly relationships.

___ b. I get completely involved in a project.

___ c. I want my ideas to be used.

___ a. I desire unique accomplishments.

___ b. I don't like being left out of things.

___ c. I enjoy influencing the direction of things.

___ a. I think about consoling and helping others.

___ b. I am verbally fluent.

___ c. I am restless and innovative.

___ a. I think about my goals and how to attain them.

___ b. I think about ways to change people.

___ c. I think about my feelings and the feelings of others.

सैक्स वाक्य परीक्षण

तिथि _____ शुरू करने का समय _____ खतम करने का समय _____

नाम _____ कक्षा _____ आयु _____

1. मुझे लगता है कि मेरे बाप कभी कभी _____
2. जब मेरे दिन बुरे होते है _____
3. मेंने हमेशा यह चाहा कि _____
4. अगर किसी काम का भार मुझे सौंपा जाता _____
5. मुझे आगे आने वाला समय _____ लगता है।
6. मेरे ऊपर के लोग _____
7. मुझे मालूम है कि यह बेवकूफी है लेकिन मै _____ से डरता हूँ।
8. मुझे लगता है कि एक सच्चा मित्र _____
9. जब मैं बच्चा था _____
10. आदर्श नारी के बारे में मेरे विचार _____
11. जब मैं एक आदमी और एक औरत को साथ – साथ देखता हूँ _____
12. ज्यादातर घरों को देखते हुये मेरा _____
13. काम करते समय मेरी सबसे ज्यादा _____ के साथ पटती है।
14. मेरी माँ _____
15. मैं उस समय को भुलाने के लिये सब कुछ करूँगा जब कि मैं _____
16. यदि मेरे बाप केवल _____
17. मुझे भरोसा है कि मुझमें _____ की योग्यता हैं।
18. मैं पूरी तरह से खुश हो सकता अगर _____
19. अगर लोग मेरे लिए काम करें _____
20. मैं आशा लगाये हूँ कि आगे _____
21. स्कूल में मेरे अध्यापक _____
22. मेरे ज्यादातर साथी यह नहीं जानते कि मैं _____ से डरता हूँ।
23. मुझे वे लोग पसंद नहीं आते जो _____
24. युद्ध के पहले मैं _____
25. मेरी समझ में ज्यादातर लड़कियां _____
26. वैवाहिक जीवन के बारे में मेरी भावना _____

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9 विद्यालय तथा विवेचनात्मक संक्षिप्त विवरण, अन्य कार्यस्थल पर साथियों के प्रति अभिवृत्ति मूल्यांकन

13 _____

28 _____

43 _____

58 _____

10 भय, मूल्यांकन

7 _____

22 _____

37 _____

52 _____

आत्म बोध (SELF CONCEPT)

11. अपराध भावनायें, मूल्यांकन

15 _____

30 _____

45 _____

60 _____

12. अपनी योग्यता के प्रति अभिवृत्ति, मूल्यांकन

2 _____

17 _____

32 _____

47 _____

13 भूतकाल के प्रति अभिवृत्ति, मूल्यांकन

9 _____

24 _____

39 _____

54 _____

14. भविष्यकाल के प्रति अभिवृत्ति, मूल्यांकन

5 _____

20 _____

35 _____

50 _____

15. लक्ष्य के प्रति अभिवृत्ति, मूल्यांकन

3 _____

18 _____

33 _____

49 _____

इन्डियन साइकलोजिकल कारपोरेशन,

लखनऊ–226 007

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27. मेरा घर मुझसे _____ ।
28. जिन लोगों के साथ मैं काम करता हूँ वे _____ का सा बर्ताव करता है ।
29. मेरी माँ और मैं _____ ।
30. मेरी सबसे बड़ी भूल थी कि _____ ।
31. अच्छा होता कि मेरे बाप _____ ।
32. मेरी सबसे बड़ी कमजोरी _____ ।
33. जीवन में मेरी गुप्त चाह _____ ।
34. वे लोग जो मेरे लिये कार्य करते हैं _____ ।
35. किसी दिन मैं _____ ।
36. जब मैं मालिक को आते हुये देखता हूँ _____ ।
37. अच्छा होता कि मैं _____ ।
38. वे लोग जो मुझे सबसे अच्छे लगते हैं _____ ।
39 यदि मैं फिर से कम उम्र होता _____ ।
40. मेरी समझ में ज्यादातर माताएँ _____ ।
41. अगर मेरे शारीरिक सम्बन्ध होते _____ ।
42. ज्यादातर परिवार जिन्हें मैं जानता हूँ _____ ।
43. मैं उन लोगों के साथ काम करना पसंद करता हूँ जो _____ ।
44. मैं सोचता हूँ कि ज्यादातर मातायें _____ ।
45. जब मैं अब से छोटा था तक मैं _____ के बारे में अपने को दोषी समझता था।
46. मुझे लगता था कि मेरे बाप _____ है।
47. जब भाग्य मेरा साथ नहीं देता _____ ।
48. दूसरों को हुकुम देतें समय मैं _____ ।
49. जीवन में मैं जिसे ज्यादा से ज्यादा चाहता हूँ _____ ।
50. जब मैं बड़ा हो जाऊँगा _____ ।
51. जिन लोगों को मैं अपने से ऊचाँ समझता हूँ _____ ।
52. मेरे भय कभी–कभी मुझे _____ के लिये मजबूर कर देते हैं ।
53. जब मैं सामने नहीं होता तो मेरे मित्र _____ ।
54. मेरे बचपन की सबसे साफ याद _____ ।
55. औरतों में मुझे सबसे कम अच्छा लगता है कि _____ ।
56. मेरा यौन जीवन _____ ।
57. जब मैं बच्चा था, मेरा घर _____ ।
58. जो लोग मेरे संग काम करते हैं आमतौर से _____ ।
59. मैं अपनी माँ को चाहता तो हूँ लेकिन _____ ।
60. सबसे बुरा काम जो मैंने कभी किया _____ ।

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परिवार (FAMILY AREA)

1 माँ के प्रति अभिवृत्ति मूल्यांकन

14 _____

29 _____

44 _____

59 _____

2 बाप के प्रति अभिवृत्ति मूल्यांकन

1 _____

16 _____

31 _____

46 _____

3 परिवारिक इकाई के प्रति अभिवृत्ति, मूल्यांकन

12 _____

27 _____

42 _____

57 _____

लिंग (SEX AREA)

4 नारी के प्रति अभिवृत्ति, मूल्यांकी

10 _____

25 _____

40 _____

55 _____

5 विपरीत लिंगीय सम्बन्धों के प्रति अभिवृत्ति, मूल्यांकन

11 _____

26 _____

41 _____

56 _____

समलैंगिक सम्बन्ध (INTERPRESONAL RELATIONSHIP)

6 मित्रों व परिचितों के प्रति अभिवृत्ति, मूल्यांकन

8 _____

23 _____

38 _____

53 _____

7 विद्यालय व अन्य कार्यस्थल पर अपने से श्रेष्ठ लोगों के प्रति अभिवृत्ति, मूल्यांकन

6 _____

21 _____

36 _____

51 _____

8 अपरिचित लोगों के प्रति अभिवृत्ति, मूल्यांकन

4 _____

19 _____

34 _____

48 _____

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